MEDICAID MANAGEMENT INFORMATION SYSTEM

PROVIDER MANUAL FOR DENTAL SERVICES

Published By:

Medical Services
North Dakota Department of Human Services
600 E Boulevard Ave, Dept 325
Bismarck, ND 58505-0250

February 2005

TABLE OF CONTENTS

STATE DIRECTORY

ADDRESSES & TELEPHONE NUMBERS

VERIFY

Recipient Eligibility
Verification System:
(701) 328-2891
1-800-428-4140
Operational Problems
(701) 328-4470

MEDICAID INQUIRIES

Provider Relations
Medical Services
ND Department of Human Services
600 E Boulevard Ave-Dept 325
Bismarck, ND 58505
(701) 328-1714
1-800-755-2604

DENTAL Consultant:

(701) 328-2321 (Monday mornings 8:00 a.m. - 10:00 a.m.)

TO OBTAIN THE FOLLOWING MEDICAID FORM:

SFN 639 Provider Request for an Adjustment

The above form is available on http://www.state.nd.us/eforms or by calling: Provider Enrollment (701) 328-4033.

CSHS INQUIRIES & TO OBTAIN FORMS:

Children's Special Health Services
ND Department of Human Services
600 E Boulevard Ave
Bismarck, ND 58505-0269
(701) 328-2436

INTRODUCTION

On September 1, 1978, the state of North Dakota began operation of the Medicaid Management Information system (MMIS). The MMIS is an automated claims processing system that allows the state to monitor the Medicaid Program and contributes to more efficient claims processing. This system provides the fastest method of claims processing and payment to providers. Currently the department uses the 1999 version 2000 and 2002 ADA claim forms.

When filing claims with the Medicaid program, the provider agrees to accept payment as payment in full. The provider CANNOT BILL the recipient for any part of the bill unless the Remittance Advice indicates a recipient liability, or if a co-payment applies to the services.

This billing manual is designed to aid providers in billing the North Dakota Medicaid, Vocational Rehabilitation (VR) and Children's Special Health Services (CSHS) programs. Included are general items of interest to providers, specific claim form billing instructions and procedures to follow when requesting adjustments to payments. You should find this manual helpful in meeting the requirements of the claims processing system. Should you have any questions, please contact the Medical Services office. Addresses and telephone numbers are listed in the State Directory section of this manual.

Any disputes or questions on claims should be directed to the Provider Relations Unit at 701-328-1714.

THIRD PARTY LIABILITY

The Medicaid program is always the secondary carrier to all other insurance programs and should be billed only after payment or denial from all other carriers. This includes private insurance, Medicare, and absent parents responsible for medical services.

When CSHS issues an authorization, it is also responsible for identifying the existence of third party coverage for a recipient. When it is determined that other insurance does exist, the CSHS agency must describe the coverage on those authorizations.

Third Party Liability (TPL) information for Medicaid recipients is available by calling the patient eligibility verify system (VERIFY) at (701) 328-2891 or 1-800-428-4140. For more information refer to the VERIFY section of this manual.

PROVIDER ROLE IN NOTIFICATION OF THIRD PARTY RESOURCES

If a provider is made aware of any other insurance or responsible party for a recipient, it is the provider's responsibility to identify those resources and notify the county agency of such if the department is unaware of those resources.

If TPL is not checked with the VERIFY system, and claims for Medicaid recipients with TPL are submitted, the claims will be returned for submission to the appropriate company or responsible party.

When TPL is indicated for a Medicaid recipient, providers must bill the appropriate third party to collect any payment from the third party prior to requesting Medicaid payment. If no benefits are payable or partial payment has been received, claim submission may be made at any time following formal notification from the third party with an explanation of benefits (EOB) attached. In the event of inability to collect from a third party, you may call the state office TPL unit 701-328-3507 for further assistance.

All claim forms submitted must indicate the third party reimbursement amount.

Federal regulations require that all claims must be filed with the department within one year of the date of service. Therefore, providers should bill before the one year time limit. **IT IS SUGGESTED THAT IF THE ONE YEAR DEADLINE IS NEARING AND THE PROVIDER HAS BILLED THIRD PARTY, BUT HAS NOT RECEIVED AN EOB, THE PROVIDER SHOULD BILL THE STATE TO MEET THIS TIME LIMITATION.** Please indicate on these claims that insurance has been billed, but payment has not been received.

DEVELOPMENTAL DISABILITY RECIPIENTS

Developmental Disability (DD) recipients may require an extra amount of time and a greater number of personnel in order to provide routine dental care. The Department has agreed to provide additional compensation to dentists who treat these recipients. Providers who treat these individuals will receive the standard fee for the dental services provided plus a special payment for the extra time needed to treat these recipients.

The policy does not require providers to document the extra time required to provide services to DD recipients. The provider is to use Procedure Code D9920 and enter the extra usual and customary charge associated with the services provided to the DD recipient. The department will pay the extra charge not to exceed $100 per visit. If the usual and customary charge exceeds $100, it will be necessary to include documentation showing the time and staff involved in the remarks section of the claim form. The Department's dental consultant will review and price those claims that exceed $100.

The Department has obtained a list from the DD facilities of those recipients who currently require extra time from dentists. At the time a bill is submitted with code D9920 department staff will compare the name to the recipient list. If the name is on the list, payment will be made not to exceed the upper limit. If the recipient is not on the list, the service will be denied for payment.

If you provide a service to a DD recipient who requires extra time, but is not on the list you will need to contact the DD provider. If the DD provider concurs that the recipient requires extra time, they will advise the Developmental Disability Division who will in turn inform our office so that the recipient can be added to the list. The Extra Time for DD Recipients form is included in this manual. This form may be duplicated for your use.

If you have any additional questions regarding this policy, contact Provider Relations at (701) 328-1714.

REQUEST FOR EXTRA TIME WITH DD RECIPIENTS

North Dakota Department of Human Services
Medical Services
600 E Boulevard Ave-Dept 325
Bismarck, ND 58505-0250

Date: _____

TO: _____
_____
_____
_____

SUBJECT: Extra Time for Developmental Disability (DD) Recipients

RE: _____

We have received a claim requesting the payment for extra time for the above named recipient. Prior to processing this claim, we need to verify that extra time is required. You need to check with the recipient or DD provider who brought the recipient to your office to verify the recipient needs extra time. Please have the DD provider sign the bottom of this letter acknowledging the fact the recipient requires extra time.

We are returning your claim with this memo and request you return the claim and completed form as soon as possible. We appreciate your continued participation in the North Dakota Medicaid Program.

If you have any questions, please call Provider Relations at (701) 328-1714.

☐ **Recipient needs extra time**

☐ **Recipient does not require extra time.**

Name of DD Provider _____

Signature of authorized individual from DD Provider _____

Return the completed form to:	Medical Services North Dakota Department of Human Services 600 E Boulevard Ave-Dept 325 Bismarck ND 58505-0250

DENTAL PRIOR TREATMENT AUTHORIZATION AND REQUEST

1. Prior authorization must be obtained from all dental providers for the following dental procedures for Medicaid eligible recipients before services are started. The Department may refuse payment for any covered service or procedure for which a Prior Treatment Authorization Request (PTAR) is required but not obtained. The Department shall consider making payment if the provider demonstrates that the failure to obtain the required PTAR was the result of oversight and the provider has not failed to obtain a PTAR within the twelve months prior to the month in which the services or procedures were furnished.

   If the Department denies payment based on the provider's failure to submit the prior approval, the provider cannot bill the recipient. If the Department denies payment because the service is non-covered, the provider can bill the recipient.

Clinical Oral Examinations:

***If exceeds:**

- **Frequency Limits - 21 and over - one time per year**
  - Under 21 - two times per year

D0120 D0150 D0160

Tests and Laboratory Examinations:

D0999

Crowns- Single Restorations Only:

D2710	D2720	D2720	D2721	D2722	D2740
D2750	D2751	D2752	D2780	D2781	D2782
D2783	D2790	D2791	D2792	D2799	

Other Restorative Services:

D2953 D2960 D2961 D2962

Endodontic Therapy:

D3310 D3346

Non Surgical Periodontal Service:

D4341 D4342 D4355

Complete Dentures:

D5110 D5120

Partial Dentures:

D5211 D5212 D5213 D5214 D5281

Interim Prosthesis:

D5820 D5821

Other Removable Prosthetic Services:

D5860

Prosthodontics, Fixed:

D6210 D6211 D6212 D6240 D6241 D6242
D6245 D6250 D6251 D6252 D6253 D6545
D6548

Vestibuloplasty:

D7340 D7350

Other Repair Procedures:

D7920 D7940 D7941 D7943 D7944 D7945
D7946 D7948 D7949 D7950 D7960 D7970
D7971 D7972 D7980 D7981 D7982 D7983
D7990 D7991 D7995 D7996 D7997 D7999

Orthodontics:

D8060 D8070 D8080 D8090 D8210 D8220
D8660 D8670 D8680

2. Since endodontics could be an emergency service, no prior treatment request is required for recipients under 21. Post-operative x-rays should accompany the authorization/claim for payment.

3. All PTAR forms submitted must use code numbers and procedures shown in the North Dakota Department of Human Services Code on Dental Procedures, Nomenclature and Fees listing included in this manual.

4. When all information needed to determine approval or denial is not submitted with a request, it will be returned for the required information.

5. No payment for dental services which require prior authorization will be made unless a Dental PTAR is on file with the Department PRIOR to the date the service is started showing that the work plan was approved for the code numbers and procedures submitted on the claim.

6. Once the PTAR is submitted, the Department's dental consultant will review the plan and either approve or deny those services listed on the PTAR. LIST ONLY THE SERVICES THAT NEED PRIOR APPROVAL. The PTAR will then be returned to the provider with an approval/denial notation. When the services are approved, specific time limits within which the approved services must be performed will be entered in the remarks section of the PTAR. Also included will be a Prior Treatment Authorization Number.

7. Approval of the PTAR is only for the dental treatment plan. THIS APPROVAL DOES NOT GUARANTEE PAYMENT OR ENSURE THE ELIGIBILITY OF THE INDIVIDUAL AT THE TIME DENTAL PROCEDURES ARE COMPLETED. Payment will be based on the fee schedule on the date of service and supersedes price on PTAR.

8. The North Dakota Department of Human Services reserves final authority to approve or deny any submitted dental treatment plan.

9. Submit completed PTAR to:

Dental Consultant
Medical Services
Department of Human Services
600 E Boulevard Ave-Dept 325
Bismarck ND 58505-0250

ORTHODONTIC PROCEDURES

The Department does not reimburse interceptive or comprehensive orthodontic treatment except with referrals from ND Health Tracks, formerly EPSDT.

Dentists must submit prior treatment authorization requests for interceptive or comprehensive orthodontia services.

The Department has defined treatment options for orthodontia services in order to clarify those options and reimbursement for those services by Medicaid. They are as follows:

(1) Interceptive orthodontic treatment under the Medicaid program will include only treatment of anterior or posterior crossbite and minor treatment for tooth guidance in the transitional dentition. Interceptive treatment is not part of the comprehensive treatment plan.

(2) Comprehensive orthodontic treatment includes treatment of transitional or adolescent dentition; requires 20 or more points on an evaluation; and is begun when a child is approximately 10 years old or older but no older than 20 years of age. Treatment may incorporate several phases with specific objectives at various stages of dentofacial development.

(a) Phase I orthodontic treatment is part of a comprehensive treatment of the transitional dentition; requires 20 or more points on an evaluation; and is begun when a child is approximately 7 or 8 years of age. Special consideration may be given if the points are between 18 and 20. X-rays and a narrative description of the malocclusion may be required for review by the department's dental consultant.

(b) Phase II orthodontic treatment is part of a comprehensive treatment of transitional/adolescent dentition; is automatically prior approved if Phase I is prior approved; and, therefore, does not require points or a separate prior approval.

As with all services, the child must be eligible at the beginning of each treatment or service.

Providers must use the Malocclusion Index to evaluate the need for orthodontic treatment of Medicaid recipients.

COMPLETION OF DENTAL
PRIOR TREATMENT AUTHORIZATION AND REQUEST

1999 VERSION 2000 FORM	2002 FORM
Field 1	Field 1
Field 2 (if filing for extension)	Field 2 (if filing for extension)
Fields 8-16	Field 12-15
Field 42	Field 48
Field 44	Fields 49 and 54

- Detail lines must be completed just as on a normal claim form. Procedure dates should be left off since the procedure has not been performed. If in fact the procedure was performed before the PTAR was sent, please indicate that somewhere on the claim.

- PTARs cannot be authorized without a valid Medicaid ID Number or date of birth on the claim form. These two fields of information are most important.

- Please indicate on the claim form whether radiographs are enclosed, if this is orthodontic treatment, or an initial placement of a prosthesis. These are not required fields of information, but make processing of the PTAR much faster.

AMERICAN DENTAL ASSOCIATION (ADA) FORMS

Effective for claims received on or after January 1, 2004, the department will accept ONLY the 1999 version 2000 and 2002 ADA Dental Claim Forms. There are numerous problems created within the department by trying to work with many different dental claim forms and all of them delay processing of the claims due to variations in data placement and therefore identification for reviewing and data entry.

Copies of the allowable Dental Claim Forms are located in the manual for your reference.

The North Dakota Department of Human Services encourages the submission of electronic claims. This is preferred as it reduces claim processing time resulting in faster payment of claims. Contact Provider Enrollment at (701) 328-4033 for more information.

GENERAL TIPS FOR BILLING

1. Bill your usual and customary charges to the general public for each service itemized.

2. It is important that all pertinent blocks on the claim form be completed. Omission of data may result in claim processing delays or return of the claim.

3. Insure that all information on a claim form is **LEGIBLE**.

4. All monetary amounts must be entered without dollar signs, decimal points or spaces. The amounts must be shown as dollars and cents. EX: Twenty dollars would be shown as 2000.

5. Strive for accuracy. Careful erasing is acceptable. Correction fluids and correction tapes can be used. Do not overlap information from one column to another. **DO NOT USE RED PEN OR INK OR HI-LIGHTERS**.

6. All dates entered should be entered as MMDDYYYY (month, day, year). EX: January 1, 2004 should be shown as 01012004. Do not use hyphens, dashes, or spaces between segments.

7. Claims **MUST** be filed with the Department within one year from the date of service.

8. For unspecified services use code D9999 and attach a report.

9. Obtain procedure codes only from the North Dakota Department of Human Services, Code on Dental Procedures, Nomenclature and Fees.

9. **PLEASE CHECK BLOCK 1, DENTIST'S STATEMENT OF ACTUAL SERVICES TO DIFFERENTIATE THE BILLING FORM FROM THE PRETREATMENT ESTIMATE FORM.**

ADA DENTAL CLAIM FORM - BILLING INSTRUCTIONS

1999 VERSION 2000 DENTAL CLAIM FORM

Field 1: **REQUIRED**... indicate whether you are submitting a statement of actual services or a request for preauthorization.

Field 2: Enter prior authorization number, if claim was prior authorized.

Fields 8-18: **REQUIRED**... Patient Information
***Field 13**...Medicaid Recipient ID Number is required. Social Security Numbers are invalid.

Fields 19-41: Required when applicable.

Fields 42-57: **REQUIRED**...Billing Information
***Field 44**...Provider ID Number is required.
***Fields 53-57**...Please complete if any apply.

DETAIL LINES

- Please enter dates in MMDDYYYY format
- Enter Tooth Number and Surfaces only if applicable
- Procedure Codes must be CDT-4 codes
- A Description must be on each detail line
- Fees must be on each line and must equal the total charge of the claim
- Claim must balance and insurance must be deducted from total charges

TOOTH NUMBERS OR LETTERS

For each detail line billed, enter the appropriate tooth number or letter being treated. Do not enter more than one letter or number for any one detail line billed. This field **MUST** be entered or the claim will suspend. Possible codes include:

A-T	Primary Teeth
1-32	Permanent Teeth
33	Whole Mouth Treated

TOOTH SURFACE

For the appropriate detail line, enter the corresponding tooth surface(s) being treated. A maximum of four surface codes may be entered in this column for any one tooth. Do not enter "A" All (Whole Tooth) with any other surface codes. This field **MUST** be entered or the claim will suspend. Possible code values include:

M - Mesial
D - Distal
O - Occlusal
L - Lingual
I - Incisal
F - Facial

MAIL TO:

Mail Medicaid and CSHS claims to:

Medical Services
North Dakota Department of Human Services
600 E Boulevard Ave-Dept 325
Bismarck ND 58505-0250

DENTAL CLAIM FORM

Dental Claim Form

©American Dental Association, 1999 version 2000

1. ☐ Dentist's pre-treatment estimate ☒ Dentist's statement of actual services — Specialty (see backside)
2. ☐ Medical Claim ☐ EPSDT — Prior Authorization #
3. Carrier Name
4. Carrier Address
5. City | 6. State | 7. Zip

PATIENT

8. Patient Name (Last, First, Middle): Doe, John M.
9. Address: 111 West St.
10. City: Bismarck
11. State: ND
12. Date of Birth (MM/DD/YYYY): 01 01 2004
13. Patient ID #: 000999999
14. Sex: ☒ M ☐ F
15. Phone Number: 701 999-9999
16. Zip Code: 58501
17. Relationship to Subscriber/Employee: ☐ Self ☐ Spouse ☐ Child ☐ Other
18. Employer/School Name / Address

SUBSCRIBER / EMPLOYEE

19. Subs./Emp. ID/SS#
20. Employer Name
21. Group #
22. Subscriber/Employee Name (Last, First, Middle)
23. Address: Required When Applicable
24. Phone Number
25. City
26. State
27. Zip Code
28. Date of Birth (MM/DD/YYYY)
29. Marital Status: ☐ Married ☐ Single ☐ Other
30. Sex: ☐ M ☐ F
39. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim.
X _____ Signed (Patient/Guardian) Date (MM/DD/YYYY)

OTHER COVERAGE

31. Is Patient covered by another plan? ☐ No (Skip 32–37) ☐ Yes ☐ Dental or ☐ Medical
32. Policy #
33. Other Subscriber's Name
34. Date of Birth (MM/DD/YYYY)
35. Sex
36. Plan/Program Name
37. Employer/School Name / Address

Required When Applicable

38. Subscriber/Employee Status: ☐ Employed ☐ Part-time Status ☐ Full-time Student ☐ Part-time Student
40. Employer/School Name / Address
41. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.
X _____ Signed (Employee/subscriber) Date (MM/DD/YYYY)

BILLING DENTIST

42. Name of Billing Dentist or Dental Entity: Dr. Smith, D.D.S.
43. Phone Number: 701 999-9999
44. Provider ID #: 40000
45. Dentist Soc. Sec. or T.I.N.
46. Address: 222 West St.
47. Dentist License #
48. First visit date of current series:
49. Place of treatment: ☐ Office ☐ Hosp. ☐ ECF ☐ Other
50. City: Bismarck
51. State: ND
52. Zip Code: 58501
53. Radiographs or models enclosed? ☐ Yes. How many? _____ ☐ No
54. Is treatment for orthodontics? ☐ Yes ☐ No. If service already commenced: Date appliances placed _____ Total mos. of treatment remaining _____
55. If prosthesis (crown, bridge, dentures), is this initial placement? ☐ Yes ☐ No. If no, reason for replacement: _____ Date of prior placement: _____
56. Is treatment result of occupational illness or injury? ☐ No ☐ Yes. Brief description and dates: _____
57. Is treatment result of ☐ auto accident? ☐ other accident? ☐ neither. Brief description and dates: _____

58. Diagnosis Code Index (optional) 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____

59. Examination and treatment plans – List teeth in order

Date (MM/DD/YYYY)	Tooth	Surface	Diagnosis Index #	Procedure Code	Qty	Description	Fee
01 01 2004				D0120		Periodic Oral Exam	20.00
01 01 2004	17	MOD		D2160		Amalgam-Three Surfaces	80.00

Admin. Use Only

60. Identify all missing teeth with "X"
Permanent: 1 2 3 4 5 6 7 8 | 9 10 11 12 13 14 15 16 | 32 31 30 29 28 27 26 25 | 24 23 22 21 20 19 18 17
Primary: A B C D E | F G H I J | T S R Q P | O N M L K

Total Fee	100.00
Payment by other plan	75.00
Max. Allowable	
Deductible	
Carrier %	
Carrier pays	
Patient pays	25.00

61. Remarks for unusual services
* Claim line charges must equal total charge... Claim must balance and insurance must be deducted

62. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.
X _____ Signed (Treating Dentist) License # Date (MM/DD/YYYY)

63. Address where treatment was performed
64. City | 65. State | 66. Zip Code

©American Dental Association, 1999
J588 (Same as ADA Dental Claim Form) – J589, J590, J591

To Reorder, call 1-800-947-4746

2002 ADA DENTAL CLAIM FORM

Field 1: **REQUIRED**... indicate whether you are submitting a statement of actual services or a request for preauthorization.

Field 2: Enter prior authorization number, if claim was prior authorized.

Field 3: Name, Address, City, State, and Zip

Fields 4-11: Leave blank if no other insurance coverage.

Field 12: **REQUIRED**... Name, Address, City, State, and Zip

Field 13: **REQUIRED**... Date of birth, in MMDDYYYY format.

Field 14: **REQUIRED**... Gender

Field 15: **REQUIRED**... Medicaid ID Number (no Social Security numbers)

Fields 18-23: Required when applicable

Field 24: **REQUIRED**... Procedure Date in MMDDYYYY format.

Fields 27-28: Required when applicable.

Field 29: **REQUIRED**... Procedure code must be a CDT-4 code

Field 30: **REQUIRED**... A description is needed on all detail lines.

Fields 31-33: **REQUIRED**... Fees must equal total charges and total charges must be in Field 33. If insurance payment needs to be deducted, show payment deduction in Field 32 and the difference in Field 33. Refer to claim example. Claim must balance.

Field 34: Report any missing teeth.

Field 35: Remarks

Field 36-37: Patient Signature and Subscriber Signature.

Fields 38-47: Required when applicable.

Field 48: **REQUIRED**... Dentist Billing Information

Fields 49 and 54: **BOTH REQUIRED**... Provider ID Number.

Fields 50 and 55: Dentist License Number

Fields 52 and 57: Provider Phone Number

Field 53: Provider Signature

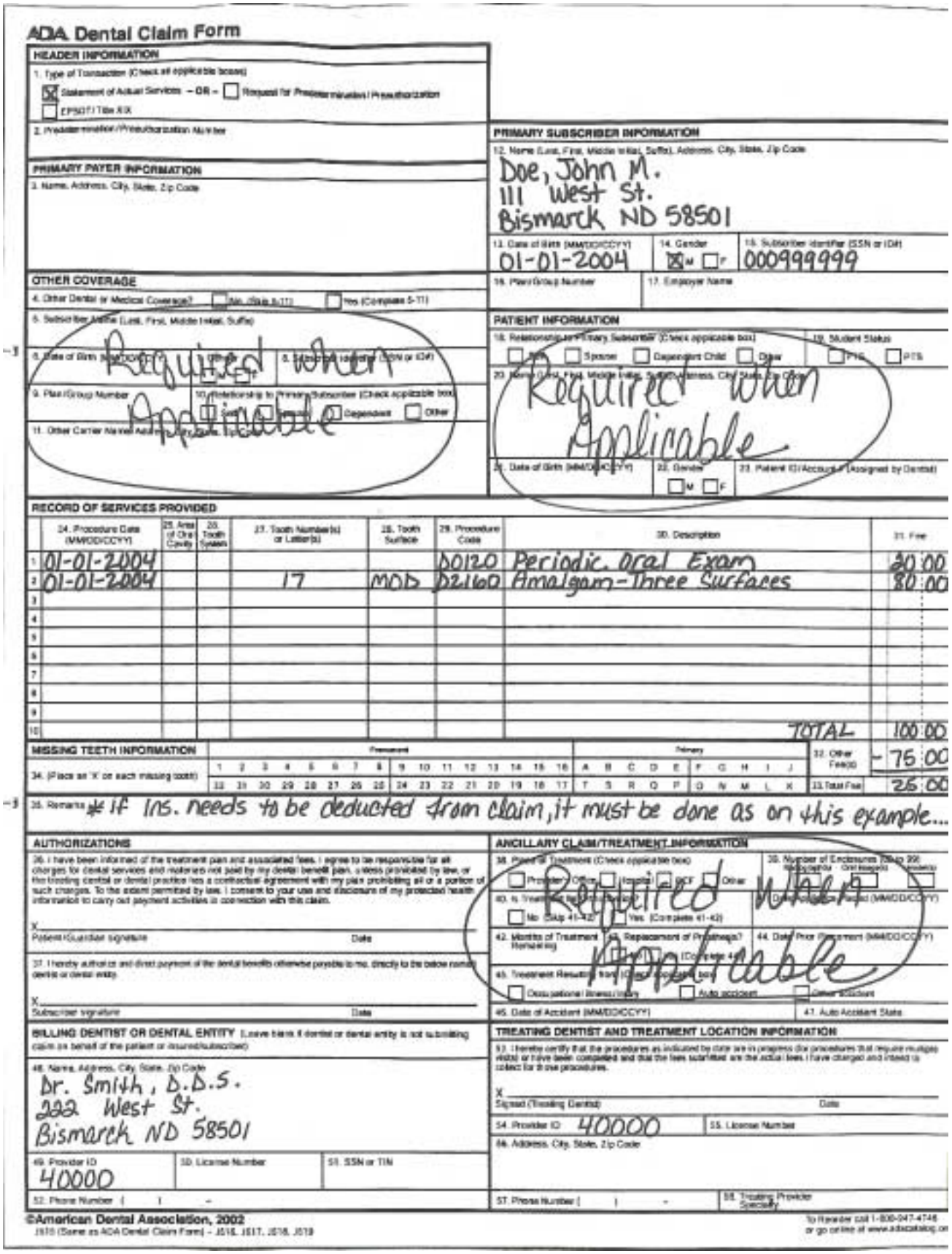
Field 56: Provider Address (required if different from Field 48)

MAIL TO:

Mail Medicaid and CSHS claims to:

Medical Services
North Dakota Department of Human Services
600 E Boulevard Ave-Dept 325
Bismarck ND 58505-0250

ADA DENTAL CLAIM FORM



ADA Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Check all applicable boxes)
☒ Statement of Actual Services – OR – ☐ Request for Predetermination / Preauthorization
☐ EPSDT / Title XIX

2. Predetermination / Preauthorization Number

PRIMARY PAYER INFORMATION

3. Name, Address, City, State, Zip Code

PRIMARY SUBSCRIBER INFORMATION

12. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
Doe, John M.
111 West St.
Bismarck ND 58501

13. Date of Birth (MM/DD/CCYY): 01-01-2004
14. Gender: ☒ M ☐ F
15. Subscriber Identifier (SSN or ID#): 000999999

16. Plan/Group Number
17. Employer Name

OTHER COVERAGE

4. Other Dental or Medical Coverage? ☐ No (Skip to 11) ☐ Yes (Complete 5-11)
5. Subscriber Name (Last, First, Middle Initial, Suffix)
6. Date of Birth (MM/DD/CCYY) 7. Gender ☐ M ☐ F 8. Subscriber Identifier (SSN or ID#)
9. Plan/Group Number
10. Relationship to Primary Subscriber (Check applicable box) ☐ Spouse ☐ Dependent ☐ Other
11. Other Carrier Name, Address, City, State, Zip Code

Required when Applicable

PATIENT INFORMATION

18. Relationship to Primary Subscriber (Check applicable box) ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other
19. Student Status ☐ FTS ☐ PTS
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

Required when Applicable

21. Date of Birth (MM/DD/CCYY)
22. Gender ☐ M ☐ F
23. Patient ID / Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1	01-01-2004					D0120	Periodic Oral Exam	20 00
2	01-01-2004			17	MOD	D2160	Amalgam-Three Surfaces	80 00
3								
4								
5								
6								
7								
8								
9								
10							TOTAL	100 00

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)

Permanent																Primary										32. Other Fee(s)	-75 00
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J	33. Total Fee	25 00
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K		

35. Remarks * If Ins. needs to be deducted from claim, it must be done as on this example...

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X
Patient/Guardian signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X
Subscriber signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment (Check applicable box) ☐ Provider's Office ☐ Hospital ☐ SNF ☐ Other
39. Number of Enclosures (Skip 39) Model(s) Only Report(s) Only Both Report(s) and Model(s)
40. Is Treatment for Orthodontia? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)
Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment Remaining
43. Replacement of Prosthesis? ☐ Yes (Complete 44)
44. Date Prior Placement (MM/DD/CCYY)
45. Treatment Resulting from (Check applicable box) ☐ Occupational Illness / Injury ☐ Auto accident ☐ Other Accident
46. Date of Accident (MM/DD/CCYY)
47. Auto Accident State

Required when Applicable

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code
Dr. Smith, D.D.S.
222 West St.
Bismarck ND 58501

49. Provider ID: 40000
50. License Number
51. SSN or TIN
52. Phone Number ( ) -

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

X
Signed (Treating Dentist) Date

54. Provider ID: 40000
55. License Number
56. Address, City, State, Zip Code
57. Phone Number ( ) -
58. Treating Provider Specialty

J910 (Same as ADA Dental Claim Form) – J016, J017, J018, J019

To Reorder call 1-800-947-4746 or go online at www.adacatalog.com

GENERAL TIPS FOR ADJUSTMENTS TO PAYMENTS

ADJUSTMENTS

If you feel an error has been made in payment as shown on your remittance advice, use the Adjustment Request form SFN 639 to request an adjustment. Please follow the instructions on the following pages for completing the Adjustment Request.

Send the completed Provider Request for an Adjustment Request for Medicaid recipients to:

Medical Services
North Dakota Department of Human Services
600 E Boulevard Ave-Dept 325
Bismarck ND 58505-0250

For the Children's Special Health Services program, send all Provider Requests for an Adjustment to:

Children's Special Health Services
North Dakota Department of Human Services
600 E Boulevard Ave
Bismarck ND 58505-0269

REFUNDS OR ADJUSTMENTS

If you discover that you have been overpaid by Medicaid or CSHS, please identify the error by writing to the appropriate address above. Refunds may be handled in one of two ways at the provider's option:

1. Send a copy of your remittance advice, circling the amount of overpayment. Complete a Provider Request for an Adjustment (SFN 639) explaining why you have been overpaid. The amount of overpayment will be reduced from a subsequent payment.

PROVIDER REQUEST FOR AN ADJUSTMENT - INSTRUCTIONS
FORM SFN 639

The Provider Request for an Adjustment Form (SFN 639) is to be used by a provider in requesting an adjustment to a previously submitted claim. Information supplied on the form should be as complete as possible, so that the problem can quickly be identified and a solution determined. Normally, such data is obtained from either the provider's copy of the claim in question or the Remittance Advice (R/A). **DO NOT** submit more than one problem claim on any single Provider Request for an Adjustment Form.

When completing the form, enter the information as printed on the Remittance Advice. If you believe this information is incorrect and necessitates a payment adjustment, explain in Block 17 (Explanation/Remarks).

Provider Request for Adjustment forms must be legible to be processed; if not, they will be denied.

(Sample Attached)

Block (1) Reason for Request:

Check the reason(s) which defines why the adjustment request is being submitted. Possible reasons include:

A. No Payment

B. Overpayment:

Payment for services rendered was more than the proper amount (See "Refunds" in this manual).

C. Underpayment:

Payment for services rendered was less than the proper amount.

D. Corrected Billing Attached:

Additional billing information is furnished with the adjustment request.

E. Paid to Wrong Provider:

The provider received payment for services on a recipient who was treated by a provider other than the one listed.

F. Cannot Identify Beneficiary on Explanation of Benefits (Remittance Advice):

The recipient number/name/case number on the provider's Remittance Advice (R/A) cannot be read, or the recipient listed is not a patient of the provider.

G. Lost Check:

The provider's payment check has been misplaced or destroyed.

H. Other (Please Clarify Under Remarks):

Include brief statement of explanation.

Block (2) Recipient Block:

A. I.D. No.: The 9-digit Medicaid Identification Number of the patient.

B. NA

C. Patient's name: The recipient's correct name must appear here.

D. Case No.: Not required.

Block (3) Provider's Name:

The provider's name and address must be inserted into this block.

Block (4) Claim's Internal Control Number (ICN):
(Sample Attached)

The 13-digit internal control number of the claim in question, obtained from the R/A, MUST be entered in this field if you are changing or correcting a previously processed claim.

Block (5): Not Required

Block (6) Provider Number:

The provider number assigned by the North Dakota Medicaid program must be inserted in this block.

Block (7) Remittance Advice Date:

If a Remittance Advice (RA) has been issued on the claim in question, place its date of issue in this block. Obtain the RA date from the upper left hand corner of the RA above the provider number.

Blocks (8) - (16):

These blocks must be completed to adjust particular detail(s) on the claim form. Examples include:

(1) You used an invalid code on the third line of the claim. The rest of the lines on the claim paid correctly but the third line was rejected. In Blocks (8) through (16) enter the information on the third line exactly as it appeared on the original claim or Remittance Advice. In Block (17) Explanation/Remarks enter the correct information.

(2) If correcting the information in the "Header" section of the claim (Blocks 1 through 35) such as the PTAR number was omitted on original claim, complete only Blocks (8) and (14) of the middle section. Enter the correct information under Block (17). For this example, use the wording "The PTAR number was omitted on the original claim; the number is _____."

Block (8) Date of Service:

Indicate in this block the exact date(s) on which each service in question was rendered.

Block (9) Units:

Enter in this block the units value listed on the RA or on the original authorization.

Block (10) Place of Service:

Block (11) Procedure Code:

The code of the service in question must be entered in this block. This code may be obtained from the provider's copy of the original claim or from the RA in the field labeled "Service Code."

Block (12) Mod."

Not applicable to dental providers.

Block (13) Tooth Number/Tooth Surface:

Enter the appropriate Tooth Number/Tooth Surface.

Block (14) Amount Billed:

The amount claimed by the provider on the original claim, as due for a service rendered, may be obtained from either the original claim or the RA.

Block (15) Amount Paid:

The amount which was actually paid for a service in question may be obtained from the RA only.

Block (16) Total:

The total of Blocks billed (14) and paid (15).

Block (17) Explanation/Remarks:

Describe in this block the nature of the problem or condition which you feel should be reviewed as a possible adjustment. Include all information you believe will be helpful in determining the correct solution.

Mail To:

This block contains the address to which the adjustment request should be sent for processing.

Block (19) Provider's Signature:

The provider's business name, telephone number, and date of request must be entered in this block. The provider or designee signature must be entered on the second line "By _____."

PROVIDER REQUEST FOR AN ADJUSTMENT

PROVIDER REQUEST FOR AN ADJUSTMENT
ND DEPARTMENT OF HUMAN SERVICES
SFN 639 (10-97)

(1) Reason for Request:

☐ A. No Payment Received ☐ B. Overpayment ☐ C. Underpayment ☐ D. Corrected Billing Attached
☐ E. Paid to Wrong Provider ☐ F. Cannot Identify Beneficiary on Explanation of Benefits ☐ G. Lost Check
☐ H. Other (Please Clarify Under Remarks)

(2) Recipient Block:

a. ID No. Patients Medicaid Number

b. Patient's Name Patient Name

c. Case Number

(3) Provider's Name: Provider Name

Address

(4) Claim's Internal Control Number: 10041317393170
Found on Remit Advice See Sample below

(5)

(6) Provider No.: 40000 as it appears on Remit

(7) Remittance Advice Date: 01 (MO) 01 (DAY) 2004 (YEAR)
Found in upper Left corner of Remit

(8) Dates of Service: From Mo	Day	Yr	Thru Mo	Day	Yr	(9) Units	(10) Place of Service	(11) Procedure/Ancillary/ Accommodation Code	(12) Modifier	(13) Tooth Number/ Tooth Surface	(14) Amount Billed	(15) Amount Paid
01	01	04	01	01	04			D06790			$455.85	$0.00
									(18) Total		$455.85	$0.00

The ICN Number is 10041317393170

(17) Explanation/Remarks:

Please reprocess with Prior Auth Number 511446

Samp ICN Number:

1 000 20-9158 09-000779-527 Smith Will 000000000
2 1004317393170 101801-101801 03330 15
1.0 490.00

Medical Services
N.D. Department of Human Services
600 E. Boulevard Avenue
Bismarck, ND 58505-0250
38124

(18) Provider's Signature:

Date: 05 (MO) 17 (DAY) 04 (YEAR)

Telephone Number

By:

VERIFICATION OF ELIGIBILITY

MEDICAID

VERIFY is a recipient eligibility verification system provided by the state of North Dakota for the provider community. This system allows you to enter the patient identification number using a touchtone telephone and receive a verbal response from the computer indicating the name and date of birth of the patient; the patient's eligibility for a given date of service; Coordinated Services Program information; existence of any third party liability (TPL); and if so, the name of the TPL carrier and the TPL policy number; amount of recipient liability, if any; co-pay; date of last eye exam, frames and lenses, and also the name of the primary care physician (PCP). All responses reflect the latest information available on the data base at the time of the call.

The following page provides instructions that will guide you through the steps necessary to use the VERIFY system.

CSHS AND VR

CSHS and Vocational Rehabilitation (VR) eligibility information is not available on the VERIFY system. Eligibility for VR recipients must be determined by contacting the regional VR office. Eligibility for CSHS recipients must be determined by contacting the state CSHS office.

WOMEN'S WAY

Women's Way is a breast and cervical cancer early detection program available to eligible North Dakota women. Women who are determined to be eligible for Women's Way are entitled to full Medicaid coverage, including dental. Women's Way eligibility information is not available on the VERIFY system. Women's Way recipient identification numbers begin with WW0000000. Eligibility for Women's Way recipients must be determined by contacting Medical Services at 701-328-1714.

VERIFY OPERATIONAL STEPS

FOR ALL VOICE RESPONSES

1. Dial (701) 328-2891 or 1-800-428-4140 (Receive Message)
2. Enter PROVIDER NUMBER and PRESS # (Receive Message)
3. Enter PATIENT ID NUMBER and PRESS # (Receive Message)
4. Enter DATE OF SERVICE and PRESS # (Receive Message)
5. Enter "2" if no more inquiries and to end call

   OR,

   Enter "1" for additional inquiries and repeat 3 and 4 above.

FOR SPEED DIALING

1. Dial (701) 328-2891 or 1-800-428-4140 (Receive Message)
2. Enter PROVIDER NUMBER and PRESS #, PATIENT ID NUMBER and PRESS #, DATE OF SERVICE and PRESS # (Receive Message)
3. Enter "2" if no more inquiries and to end call

   OR,

   Enter "1" for additional inquiries and repeat 2 above using PATIENT ID and PRESS # and DATE OF SERVICE and PRESS #

TO REPEAT INFORMATION

1. Enter "*" to repeat current message
2. Enter "1" for Eligibility and Recipient Liability
3. Enter "2" for Coordinated Services Program and Primary Care Physician (PCP)
4. Enter "3" for Co-Payment
5. Enter "4" for Third Party Liability (TPL)
6. Enter "5" for Vision
7. Enter "6" for ALL Menu items

FOR CURRENT DATE, PRESS # KEY, INSTEAD OF 8-DIGIT DATE

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
CDT-4 CODE ON DENTAL PROCEDURES, NOMENCLATURE AND FEES

January 1, 2004

CATEGORY OF SERVICE		CODE SERIES
I.	Diagnostic	D0100-D0999
II.	Preventive	D1000-D1999
III.	Restorative	D2000-D2999
IV.	Endodontics	D3000-D3999
V.	Periodontics	D4000-D4999
VI.	Prosthodontics, removable	D5000-D5899
VII.	Maxillofacial Prosthetics	D5900-D5999
VIII.	Implant Services	D6000-D6199
IX.	Prosthodontics, fixed	D6200-D6999
X.	Oral and Maxillofacial Surgery	D7000-D7999
XI.	Orthodontics	D8000-D8999
XII.	Adjunctive General Services	D9000-D9999

PROCEDURES WITH TIME LIMITATIONS

The following procedures are limited as to the frequency they are paid for by the North Dakota Medicaid program. Exceptions may be granted by our dental consultant based on medical necessity. Providers must submit a Prior Treatment Authorization Request (PTAR) form prior to treatment and indicate the medical reason.

D0120, D0150, D0160	Adult	1 per year only
D0330	Panoramic Film - Child	5 years
D0330	Panoramic Film - Adult	Initial visit only
D1110	Prophylaxis - Adult	1 per year
D1120	Prophylaxis - Child	2 per year
See }	Replacement Dentures	5 years
Specific }	Rebase/Reline of immediate/emergency denture	1 year
Code }	Rebase/Reline of other dentures	2 years

EXPLANATION OF SYMBOLS

Restrictions/limits for certain codes are identified by the symbols "*" or "+" immediately preceding the code number. The symbol "SC" preceding the fee amount denotes special consideration as explained below. "NC" denotes a non-covered service.

*	Requires Prior Authorization
+	Not Authorized for Recipients Over 18 Years of Age
❑	Frequency Limits
SC	"Special Consideration" will be given the claims preceded by an "SC". The provider of service must submit a PTAR with a full explanation of the procedure justifying the service and amount claimed. The explanation should accompany the claim when billed.
NC	"Not a Covered" service

BILLING

Providers must bill their usual and customary charges. The amounts listed per procedure are the maximum amounts allowed (paid) by the Department.

I. D0100-D0999 DIAGNOSTIC

CLINICAL ORAL EXAMINATIONS

❑	D0120	Periodic oral examination	19.70	15.45
	D0140	Limited oral evaluation-problem focused (Requires description Box 38)	27.10	21.80
❑	D0150	Comprehensive oral evaluation (new or established patient)	29.75	23.95
❑	D0160	Detailed and extensive oral evaluation - problem focused by report	73.40	58.50
	D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	19.70	15.45
	D0180	Comprehensive periodontal evaluation - new or established patient	29.75	23.95

RADIOGRAPHS

D0210	Intraoral - complete series (including bitewings)	56.85	45.80
D0220	Intraoral - periapical - first film	11.65	9.65
D0230	Intraoral - periapical - each additional film	8.55	6.90
D0240	Intraoral - occlusal film	21.30	17.05
D0250	Extraoral - first film	NC	NC
D0260	Extraoral - each additional film	NC	NC
D0270	Bitewing - single film	11.65	9.65
D0272	Bitewings - two films	18.60	14.95
D0274	Bitewings - four films	23.95	19.20
D0277	Vertical bitewings - 7 to 8 films	NC	NC
D0290	Posterior-anterior or lateral skull and facial bone survey film	NC	NC
D0310	Sialography	NC	NC
D0320	Temporomandibular joint arthrogram, including injection	NC	NC
D0321	Other temporomandibular joint films, by report	NC	NC
D0322	Tomographic survey	21.30	21.30
D0330	Panoramic film - 5 years	48.40	38.80
D0340	Cephalometric film	NC	NC
D0350	Oral/facial images (includes intra and extraoral images)	NC	NC

❑ **Frequency Limits - 21 and over - one time per year – Under 21 - two times per year**

January 1, 2004		Under 21	21 & Over
	TESTS AND LABORATORY EXAMINATONS		
D0415	through D0480	NC	NC
D0502	Other oral pathology procedures, by report	SC	SC
D0999	Unspecified diagnostic procedures, by report	SC	SC
II.	D1000-D1999 PREVENTIVE		
	DENTAL PROPHYLAXIS		
D1110	Prophylaxis - adult - 1 per year (permanent dentition)	37.20	34.00
D1120	Prophylaxis - child - 2 per year	25.55	0
	TOPICAL FLUORIDE TREATMENT		
D1201	Topical application of fluoride (including prophylaxis) - child	42.55	0
D1203	Topical application of fluoride (prophylaxis not included) - child	17.05	0
D1204	Topical application of fluoride (prophylaxis not included) - adult	0	13.80
D1205	Topical application of fluoride (including prophylaxis) - adult	0	43.60
	OTHER PREVENTIVE SERVICES		
D1310	Nutritional counseling for the control of dental disease	NC	NC
D1320	Tobacco counseling for the control and prevention of oral disease	NC	NC
D1330	Oral hygiene instructions	NC	NC
D1351	Sealant - per tooth	20.25	NC
	SPACE MAINTENANCE (PASSIVE APPLIANCES)		
D1510	Space maintainer - fixed - unilateral	143.55	NC
D1515	Space maintainer - fixed - bilateral	213.70	NC
D1520	Space maintainer - removable - unilateral	42.55	NC
D1525	Space maintainer - removable - bilateral	132.95	NC
D1550	Re-cementation of space maintainer	30.90	NC

January 1, 2004		Under 21	21 & Over

III. D2000-D2999 RESTORATIVE

AMALGAM RESTORATIONS (INCLUDING POLISHING)

D2140	Amalgam - one surface, primary or permanent	50.95	44.65
D2150	Amalgam - two surfaces, primary or permanent	62.30	55.75
D2160	Amalgam - three surfaces, primary or permanent	75.85	73.65
D2161	Amalgam - four or more surfaces, primary or permanent	94.00	83.75

RESIN-BASED COMPOSITE RESTORATIONS - DIRECT

D2330	Resin-based composite - one surface, anterior	61.75	55.75
D2331	Resin-based composite - two surfaces, anterior	74.20	65.85
D2332	Resin-based composite - three surfaces, anterior	92.30	78.10
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	111.65	108.30
D2390	Resin-based composite crown, anterior	NC	NC
D2391	Resin-based composite - one surface, posterior	50.95	44.65
D2392	Resin-based composite - two surfaces, posterior	62.30	55.75
D2393	Resin-based composite - three surfaces, posterior	75.85	73.65
D2394	Resin-based composite - four or more surfaces, posterior	94.00	83.75

GOLD FOIL RESTORATIONS

D2410	through D2430	NC	NC

INLAY/ONLAY RESTORATIONS

D2510	through D2664	NC	NC

CROWNS - SINGLE RESTORATIONS ONLY

X-rays and PTAR required on all crowns except stainless steel.

*	D2710	Crown - resin (indirect)	298.45	NC
*	D2720	Crown - resin with high noble metal	492.60	NC
*	D2721	Crown - resin with predominantly base metal	492.60	NC
*	D2722	Crown - resin with noble metal	492.60	NC
*	D2740	Crown - porcelain/ceramic substrate	492.60	NC
*	D2750	Crown - porcelain fused to high noble metal	464.00	NC
*	D2751	Crown - porcelain fused to predominantly base metal	425.15	NC
*	D2752	Crown - porcelain fused to noble metal	446.65	NC
*	D2780	Crown - 3/4 cast high noble metal	NC	NC

*	D2781	Crown - 3/4 cast predominantly base metal	NC	NC
*	D2782	Crown - 3/4 cast noble metal	NC	NC
*	D2783	Crown - 3/4 porcelain/ceramic	NC	NC
*	D2790	Crown - full cast high noble metal	453.80	NC
*	D2791	Crown - full cast predominantly base metal	382.25	NC
*	D2792	Crown - full cast noble metal	446.65	NC
*	D2799	Provisional crown	NC	NC

*** REQUIRES PTAR**

OTHER RESTORATIVE SERVICES

	D2910	Recement inlay	41.00	33.00
	D2920	Recement crown	41.50	33.50
	D2930	Prefabricated stainless steel crown - primary tooth	97.90	79.80
	D2931	Prefabricated stainless steel crown - permanent tooth	114.85	127.60
	D2932	Prefabricated resin crown	165.90	NC
	D2933	Prefabricated stainless steel crown with resin window	112.70	95.70
	D2940	Sedative filling	43.60	34.55
	D2950	Core buildup, including any pins	102.05	NC
	D2951	Pin retention - per tooth, in addition to restoration	20.25	16.45
	D2952	Cast post and core in addition to crown	151.00	NC
	D2953	Each additional cast post - same tooth		NC
*	D2954	Prefabricated post and core in addition to crown	146.75	SC (Anterior only)
	D2955	Post removal (not in conjunction with endodontic therapy)	31.90	NC
	D2957	Each additional prefabricated post - same tooth	NC	NC
*	D2960	Labial veneer (resin laminate) - chairside	275.95	NC
*	D2961	Labial veneer (resin laminate) - laboratory	212.60	NC
*	D2962	Labial veneer (porcelain laminate) - laboratory	468.10	NC
	D2970	Temporary crown (fractured tooth)	127.60	NC
	D2980	Crown repair, by report	SC	SC
	D2999	Unspecified restorative procedure, by report	SC	SC

IV. D3000-D3999 ENDODONTICS

PULP CAPPING

	D3110	Pulp cap - direct (excluding final restoration)	29.75	23.95
	D3120	Pulp cap - indirect (excluding final restoration)	NC	NC

* **REQUIRES PTAR**

PULPOTOMY

	D3220	Therapeutic pulpotomy (excluding final restoration)	63.80	NC
	D3221	Pulpal debridement, primary and permanent teeth	63.80	NC

ENDODONTIC THERAPY ON PRIMARY TEETH

Endodontic therapy on primary teeth with succedaneous teeth and placement of resorbable filling.

	D3230	Pulpal therapy (resorbable filling) - anterior primary tooth (excluding final restoration)	32.40	NC
	D3240	Pulpal therapy (resorbable filling) - posterior primary tooth (excluding final restoration)	55.25	NC

ENDODONTIC THERAPY (INCLUDING TREATMENT PLAN, CLINICAL PROCEDURES, AND FOLLOW-UP CARE

Includes primary teeth without succedaneous teeth and permanent teeth.

Apicoectomy is not intended for routine treatment, but will be reviewed on a case by case basis, where such apicoectomies will result in greater cost effectiveness.

*	D3310	Anterior (excluding final restoration)	284.15	226.90*
	D3320	Bicuspid (excluding final restoration)	382.25	NC
+	D3330	Molar (excluding final restoration)	446.65	NC
	D3331	Treatment of root canal obstruction; non-surgical access	NC	NC
	D3332	Incomplete endodontic therapy; inoperable or fractured tooth	NC	NC
	D3333	Internal root repair of perforation defects	NC	NC
*	D3346	Retreatment of previous root canal therapy - anterior	340.35	271.85
+	D3347	Retreatment of previous root canal therapy - bicuspid	425.15	NC
+	D3348	Retreatment of previous root canal therapy - molar	511.00	NC
	D3351	Apexification/recalcification - initial visit	143.10	NC
	D3352	Apexification/recalcification - interim medication replacement	72.35	NC
	D3353	Apexification/recalcification - final visit	72.35	NC

*** REQUIRES PTAR**

+ NOT AUTHORIZED FOR RECIPIENTS OVER 18 YEARS OF AGE

APICOECTOMY/PERIRADICULAR SERVICES - SPECIAL CONSIDERATION

	D3410	Apicoectomy/periradicular surgery - anterior	SC	NC
	D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	SC	NC
	D3425	Apicoectomy/periradicular surgery - molar (first root)	SC	NC
	D3426	Apicoectomy/periradicular surgery (each additional root)	SC	NC
	D3430	Retrograde filling - per root	SC	NC
	D3450	Root amputation - per root	SC	NC
	D3460	Endodontic endosseous implant	SC	NC
	D3470	Intentional reimplantation (including necessary splinting)	SC	NC

OTHER ENDODONTIC PROCEDURES

	D3910	Surgical procedure for isolation of tooth with rubber dam	NC	NC
	D3920	Hemisection (including any root removal) not including root canal therapy	NC	NC
	D3950	Canal preparation and fitting of preformed dowel or post	NC	NC
	D3999	Unspecified endodontic procedure, by report	NC	NC

V. D4000 - D4999 PERIODONTICS

	D4210	through D4276	NC	NC

NON-SURGICAL PERIODONTAL SERVICE

	D4320	Provisional splinting - intracoronal	NC	NC
	D4321	Provisional splinting - extracoronal	NC	NC
*	D4341	Periodontal scaling and root planing - four or more contiguous teeth or bounded teeth spaces per quadrant	120.15	95.75
*	D4342	Periodontal scaling and root planing - one to three teeth, per quadrant	72.09	57.45
*	D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	68.10	54.20
	D4381	Localized delivery of chemotherapeutic agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report	NC	NC

OTHER PERIODONTAL SERVICES

*	D4910	Periodontal maintenance	56.95	45.80
	D4920	Unscheduled dressing change (by someone other than treating dentist)	NC	NC
	D4999	Unspecified periodontal procedure, by report	NC	NC

VI. D5000 - D5899 PROSTHODONTICS (REMOVABLE)

The Department has established limits on frequency of most dentures. Replacement will be limited to one every five years. Relining and rebasing of immediate dentures is limited to once within one year after initial placement; other relining and rebasing is limited to once every two years. Exceptions based on medical necessity can be submitted on a PTAR.

COMPLETE DENTURES (INCLUDING ROUTINE POSTDELIVERY CARE)

There is a 5-year time limitation to replace dentures.

Complete dentures (initial placement for recipient) do not require PTAR. Complete dentures (replacement) do require PTAR. ALL claims for replacement dentures must indicate in blocks 33 and 34 the age of the current denture and the reason for replacement. Dentures and partials must be billed on the date of placement.

*	D5110	Complete denture - maxillary	657.15	525.35
*	D5120	Complete denture - mandibular	657.15	525.35
	D5130	Immediate denture - maxillary	693.95	554.95
	D5140	Immediate denture - mandibular	693.95	554.95

PARTIAL DENTURES (INCLUDING ROUTINE POSTDELIVERY CARE)

There is a five-year time limitation on replacement dentures. Replacement of partial dentures before the 5-year time limit requires prior approval. ALL claims for replacement partial dentures must indicate the age of the current partial denture and the reason for replacement. We do not cover missing single posterior teeth. Dentures and partials must be billed on the date of placement.

*	D5211	Maxillary partial denture - resin base (including any anterior only conventional clasps, rests and teeth)	695.00
*	D5212	Mandibular partial denture - resin base (including any anterior only conventional clasps, rests and teeth)	695.00
*	D5213	Maxillary partial denture - cast metal framework with anterior only resin denture bases (including any conventional clasps, rests and teeth)	765.50
*	D5214	Mandibular partial denture - cast metal framework with anterior only resin denture bases (including any conventional clasps, rests and teeth)	765.50
*	D5281	Removable unilateral partial denture - one piece cast anterior only metal (including clasps and teeth)	511.00

*** REQUIRES PTAR**

January 1, 2004		Under 21	21 & Over
	ADJUSTMENTS TO DENTURES		
D5410	Adjust complete denture - maxillary	SC	SC
D5411	Adjust complete denture - mandibular	SC	SC
D5421	Adjust partial denture - maxillary	SC	SC
D5422	Adjust partial denture - mandibular	SC	SC
	REPAIRS TO COMPLETE DENTURES		
D5510	Repair broken complete denture base	76.55	74.45
D5520	Replace missing or broken teeth - complete denture (each tooth)	59.55	51.10
	REPAIRS TO PARTIAL DENTURES		
D5610	Repair resin denture base	84.05	74.45
D5620	Repair cast framework	125.45	101.05
D5630	Repair or replace broken clasp	83.50	74.45
D5640	Replace broken teeth - per tooth	63.80	51.10
D5650	Add tooth to existing partial denture	93.60	74.45
D5660	Add clasp to existing partial denture	77.65	74.45
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	NC	NC
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	NC	NC
	DENTURE REBASE PROCEDURES		
	There is a two year time limitation on rebasing complete dentures. There is a one year time limitation on immediate dentures.		
D5710	Rebase complete maxillary denture	280.05	NC
D5711	Rebase complete mandibular denture	280.05	NC
D5720	Rebase maxillary partial denture	197.25	NC
D5721	Rebase lower (mandibular) partial denture	197.25	NC
	DENTURE RELINE PROCEDURES		
	There is a two year time limitation on relining complete dentures. There is a one year time limitation on immediate dentures.		
	EXCEPTIONS on time limitations may be granted based on medical necessity. PTAR required and medical reason indicated.		

January 1, 2004			Under 21	21 & Over
	D5730	Reline complete maxillary denture (chairside)	187.05	149.25
	D5731	Reline complete mandibular denture (chairside)	187.05	149.25
	D5740	Reline maxillary partial denture (chairside)	187.05	149.25
	D5741	Reline mandibular partial denture (chairside)	187.05	149.25
	D5750	Reline complete maxillary denture (laboratory)	250.40	202.40
	D5751	Reline complete mandibular denture (laboratory)	250.40	202.40
	D5760	Reline maxillary partial denture (laboratory)	250.40	202.40
	D5761	Reline mandibular partial denture (laboratory)	250.40	202.40
		INTERIM PROSTHESIS		
	D5810	Interim complete denture (maxillary)	NC	NC
	D5811	Interim complete denture (mandibular)	NC	NC
*	D5820	Interim partial denture (maxillary) - flipper 5 years	169.65	139.00
*	D5821	Interim partial denture (mandibular) - flipper 5 years	169.65	139.00
		OTHER REMOVABLE PROSTHETIC SERVICES		
	D5850	Tissue conditioning, maxillary	50.00	40.45
	D5851	Tissue conditioning, mandibular	41.00	33.00
*	D5860	Overdenture - complete, by report	708.25	NC
	D5861	Overdenture - partial, by report	637.75	NC
	D5862	Precision attachment, by report	NC	NC
	D5867	Replacement of replaceable part of semi-precision or precision attachment (male or female component)	NC	NC
	D5875	Modification of removable prosthesis following implant surgery	NC	NC
	D5899	Unspecified removable prosthodontic procedure, by Report	SC	SC
VII.		D5900 - D5999 MAXILLOFACIAL PROSTHETICS		
		The Department will consider requests for all codes in the CDT. All prosthetics require PTAR and written report be submitted prior to treatment.		
	D5900	through D5999	SC	SC
VIII.		D6000 - D6199 IMPLANT SERVICES		
	D6010	through D6199	NC	NC

* **REQUIRES PTAR**

IX. D6200 - D6999 PROSTHODONTICS, FIXED

FIXED PARTIAL DENTURE PONTICS

*	D6210	Pontic - cast high noble metal	455.85	NC
*	D6211	Pontic - cast predominantly base metal	357.70	NC
*	D6212	Pontic - cast noble metal	357.70	NC
*	D6240	Pontic - porcelain fused to high noble metal	468.10	NC
*	D6241	Pontic - porcelain fused to predominantly base metal	419.05	NC
*	D6242	Pointic - porcelain fused to noble metal	427.20	NC
*	D6245	Pontic - porcelain/ceramic	NC	NC
*	D6250	Pontic - resin with high noble metal	335.25	NC
*	D6251	Pontic resin with predominantly base metal	335.25	NC
*	D6252	Pontic - resin with noble metal	335.25	NC
*	D6253	Provisional pontic	NC	NC

FIXED PARTIAL DENTURE RETAINERS - INLAYS/ONLAYS

*	D6545	Retainer - cast metal for resin bonded fixed prosthesis	212.60	NC
*	D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis	212.60	NC
	D6600	Inlay - porcelain/ceramic, two surfaces	NC	NC
	D6601	Inlay - porcelain/ceramic, three or more surfaces	NC	NC
	D6602	Inlay - cast high noble metal, two surfaces	NC	NC
	D6603	Inlay - cast high noble metal, three or more surfaces	NC	NC
	D6604	Inlay - cast predominantly base metal, two surfaces	NC	NC
	D6605	Inlay - cast predominantly base metal, three or more surfaces	NC	NC
	D6606	Inlay - cast noble metal, two surfaces	NC	NC
	D6607	Inlay - cast noble metal, three or more surfaces	NC	NC
	D6608	Onlay - porcelain/ceramic, two surfaces	NC	NC
	D6609	Onlay - porcelain/ceramic, three or more surfaces	NC	NC
	D6610	Onlay - cast high noble metal, two surfaces	NC	NC
	D6611	Onlay - cast high noble metal, three or more surfaces	NC	NC
	D6612	Onlay - cast predominantly base metal, two surfaces	NC	NC
	D6613	Onlay - cast predominantly base metal, three or more surfaces	NC	NC
	D6614	Onlay - cast noble metal, two surfaces	NC	NC
	D6615	Onlay - cast noble metal, three or more surfaces	NC	NC

*** REQUIRES PTAR**

January 1, 2004			Under 21	21 & Over
		FIXED PARTIAL DENTURE RETAINERS - CROWNS		
*	D6720	Crown - resin with high noble metal	318.90	NC
*	D6721	Crown - resin with predominantly base metal	318.90	NC
*	D6722	Crown - resin with noble metal	318.90	NC
	D6740	Crown - porcelain/ceramic	NC	NC
*	D6750	Crown - porcelain fused to high noble metal	468.10	NC
*	D6751	Crown - porcelain fused to predominantly base metal	424.15	NC
*	D6752	Crown - porcelain fused to noble metal	437.45	NC
*	D6780	Crown - 3/4 cast high noble metal	329.10	NC
	D6781	Crown - 3/4 cast predominantly base metal	NC	NC
	D6782	Crown - 3/4 cast noble metal	NC	NC
	D6783	Crown - 3/4 porcelain/ceramic	NC	NC
*	D6790	Crown - full cast high noble metal	455.85	NC
*	D6791	Crown - full cast predominantly base metal	408.80	NC
*	D6792	Crown - full cast noble metal	425.20	NC
	D6793	Provisional retainer crown	NC	NC
		OTHER FIXED PARTIAL DENTURE SERVICES		
	D6920	Connector bar	NC	NC
	D6930	Recement fixed partial denture	60.55	48.40
	D6940	Stress breaker	NC	NC
	D6950	Precision attachment	NC	NC
	D6970	Cast post and core in addition to fixed partial denture retainer	NC	NC
	D6971	Cast post as part of fixed partial denture retainer	NC	NC
	D6972	Prefabricated post and core in addition to fixed anterior partial denture retainer only	127.60	SC
	D6973	Core build up for retainer, including any pins	140.40	NC
	D6975	Coping - metal	NC	NC
	D6976	Each additional cast post - same tooth	NC	NC
	D6977	Each additional prefabricated post - same tooth	NC	NC
	D6980	Fixed partial denture repair, by report	NC	NC
	D6985	Pediatric partial denture, fixed	NC	NC
	D6999	Unspecified fixed prosthodontic procedure, by report	NC	NC
X.		D7000 - D7999 ORAL AND MAXILLOFACIAL SURGERY		
		EXTRACTIONS (INCLUDES LOCAL ANESTHESIA, SUTURING, IF NEEDED, AND ROUTINE POSTOPERATIVE CARE)		
	D7111	Coronal remnants - deciduous tooth	52.15	40.45
	D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	52.15	40.45

*** REQUIRES PTAR**

January 1, 2004		Under 21	21 & Over
	SURGICAL EXTRACTIONS (INCLUDES LOCAL ANESTHESIA, SUTURING, IF NEEDED, AND ROUTINE POSTOPERATIVE CARE)		
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	104.80	84.05
D7220	Removal of impacted tooth - soft tissue	119.10	95.20
D7230	Removal of impacted tooth - partially bony	153.15	122.30
D7240	Removal of impacted tooth - completely bony	174.40	139.30
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	215.85	173.35
D7250	Surgical removal of residual tooth roots (cutting procedure)	114.85	94.65
	OTHER SURGICAL PROCEDURES		
D7260	Oroantral fistula closure	42.55	42.55
D7261	Primary closure of a sinus perforation	SC	SC
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	245.30	196.25
D7272	Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization	NC	NC
D7280	Surgical access of an unerupted tooth	236.10	190.10
D7281	Surgical exposure of impacted or unerupted tooth to aid eruption	157.40	124.70
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	NC	NC
D7285	Biopsy of oral tissue - hard (bone, tooth)	233.05	188.05
D7286	Biopsy of oral tissue - soft (all others)	233.05	169.65
D7287	Cytology sample collection	NC	NC
D7290	Surgical repositioning of teeth	SC	SC
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	85.10	85.10
	ALVEOLOPLASTY - SURGICAL PREPARATION OF RIDGE FOR DENTURES		
D7310	Alveoloplasty in conjunction with extractions - per quadrant	127.60	102.05
D7320	Alveoloplasty not in conjunction with extractions - per quadrant	106.30	85.10

*** REQUIRES PTAR**

January 1, 2004			Under 21	21 & Over
		VESTIBULOPLASTY		
*	D7340	Vestibuloplasty - ridge extension (secondary epithelialization)	255.50	255.50
*	D7350	Vestibuloplasty - ridge extension (including soft issue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	255.50	255.50
		SURGICAL EXCISION OF SOFT TISSUE LESIONS		
	D7410	Excision of benign lesion up to 1.25 cm	340.35	271.90
	D7411	Excision of benign lesion greater than 1.25 cm	408.80	326.05
	D7412	Excision of benign lesion, complicated	SC	SC
	D7413	Excision of malignant lesion up to 1.25 cm	SC	SC
	D7414	Excision of malignant lesion, greater than 1.25 cm	SC	SC
	D7415	Excision of malignant lesion, complicated	SC	SC
	D7465	Destruction of lesion(s) by physical or chemical method, by report	SC	SC
		SURGICAL EXCISION OF INTRA-OSSEOUS LESIONS		
	D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm	SC	SC
	D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm	SC	SC
	D7450	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	113.80	91.45
	D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	170.15	136.10
	D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm	53.15	53.15
	D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm	79.75	79.75
		EXCISION OF BONE TISSUE		
	D7471	Removal of lateral exostosis (maxilla or mandible)	SC	SC
	D7472	Removal of torus palatinus	SC	SC
	D7473	Removal of torus mandibularis	SC	SC
	D7485	Surgical reduction of osseous tuberosity	SC	SC
	D7490	Radical resection of mandible with bone graft	SC	SC

- **REQUIRES PTAR**

SURGICAL INCISION

D7510	Incision and drainage of abscess - intraoral soft tissue	83.50	66.50
D7520	Incision and drainage of abscess - extraoral soft tissue	SC	SC
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	59.55	47.85
D7540	Removal of reaction producing foreign bodies, musculoskeletal system	SC	SC
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	SC	SC
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	SC	SC

TREATMENT OF FRACTURES - SIMPLE

D7610	Maxilla - open reduction (teeth immobilized, if present)	SC	SC
D7620	Maxilla - closed reduction (teeth immobilized, if present)	SC	SC
D7630	Mandible - open reduction (teeth immobilized, if present)	SC	SC
D7640	Mandible - closed reduction (teeth immobilized, if present)	SC	SC
D7650	Malar and/or zygomatic arch - open reduction	SC	SC
D7660	Malar and/or zygomatic arch - closed reduction	SC	SC
D7670	Alveolus - closed reduction, may include stabilization of teeth	SC	SC
D7671	Alveolus - open reduction, may include stabilization of teeth	SC	SC
D7680	Facial bones - complicated reduction with fixation and multiple surgical approaches	SC	SC

TREATMENT OF FRACTURES - COMPOUND

D7710	Maxilla - open reduction	SC	SC
D7720	Maxilla - closed reduction	SC	SC
D7730	Mandible - open reduction	SC	SC
D7740	Mandible - closed reduction	SC	SC
D7750	Malar and/or zygomatic arch - open reduction	SC	SC
D7760	Malar and/or zygomatic arch - closed reduction	SC	SC
D7770	Alveolus - open reduction stabilization of teeth	SC	SC
D7771	Alveolus, closed reduction stabilization of teeth	SC	SC
D7780	Facial bones - complicated reduction with fixation and multiple surgical approaches	SC	SC

REDUCTION OF DISLOCATION AND MANAGEMENT OF OTHER TEMPOROMANDIBULAR JOINT DYSFUNCTIONS

	D7810 through D7899	Must be submitted on PTAR and written report prior to treatment	SC	SC

REPAIR OF TRAUMATIC WOUNDS

	D7910	Suture of recent small wounds up to 5 cm	26.60	26.60

COMPLICATED SUTURING (RECONSTRUCTION REQUIRING DELICATE HANDLING OF TISSUES AND WIDE UNDERMINING FOR METICULOUS CLOSURE)

	D7911	Complicated suture - up to 5 cm	26.60	26.60
	D7912	Complicated suture - greater than 5 cm	26.60	26.60

OTHER REPAIR PROCEDURES

*	D7920	Skin graft (identify defect covered, location and type of graft)	SC	SC
*	D7940	Osteoplasty - for orthognathic deformities	SC	SC
*	D7941	Osteotomy - mandibular rami	SC	SC
*	D7943	Osteotomy - mandibular rami with bone graft; includes obtaining the graft	SC	SC
*	D7944	Osteotomy - segmented or subapical - per sextant or quadrant	SC	SC
*	D7945	Osteotomy - body of mandible	SC	SC
*	D7946	LeFort I (maxilla - total)	SC	SC
*	D7947	LeFort I (maxilla - segmented)	SC	SC
*	D7948	LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) without bone graft	SC	SC
*	D7949	LeFort II or LeFort III - with bone graft	SC	SC
*	D7950	Osseous, osteoperiosteal, or cartilage graft of the mandible or facial bones - autogenous or nonautogenous, by report	SC	SC
*	D7955	Repair of maxillofacial soft and hard tissue defect	SC	SC
*	D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure	SC	SC
*	D7970	Excision of hyperplastic tissue - per arch	SC	SC
*	D7971	Excision of pericoronal gingiva	SC	SC
*	D7972	Surgical reduction of fibrous tuberosity	SC	SC
*	D7980	Sialolithotomy	SC	SC
*	D7981	Excision of salivary gland, by report	SC	SC
*	D7982	Sialodochoplasty	SC	SC

*** REQUIRES PTAR**

January 1, 2004			Under 21	21 & Over
*	D7983	Closure of salivary fistula	SC	SC
*	D7990	Emergency tracheotomy	SC	SC
*	D7991	Coronoidectomy	SC	SC
*	D7995	Synthetic graft - mandible or facial bones, by report	SC	SC
*	D7996	Implant-mandible for augmentation purposes excluding alveolar ridge), by report	SC	SC
*	D7997	Appliance removal (not by dentist who placed appliance), includes removal of archbar	SC	SC
*	D7999	Unspecified oral surgery procedure, by report	SC	SC
XI.	D8000 - D8999 ORTHODONTICS			
	LIMITED ORTHODONTIC TREATMENT			
	D8010	Limited orthodontic treatment of the primary dentition	NC	NC
	D8020	Limited orthodontic treatment of the transitional dentition	NC	NC
	D8030	Limited orthodontic treatment of the adolescent dentition	NC	NC
	D8040	Limited orthodontic treatment of the adult dentition	NC	NC
	INTERCEPTIVE ORTHODONTIC TREATMENT			
	D8050	Interceptive orthodontic treatment of the primary dentition	NC	NC
*	D8060	Interceptive orthodontic treatment of the transitional dentition	843.15	0
	COMPREHENSIVE ORTHODONTIC TREATMENT			
*	D8070	Comprehensive orthodontic treatment of the transitional dentition (Phase I)	SC	0
*	D8080	Comprehensive orthodontic treatment of the adolescent dentition (Phase II)	SC	0
*	D8090	Comprehensive orthodontic treatment of the adult dentition (only up to age 21)	2779.85	0
	MINOR TREATMENT TO CONTROL HARMFUL HABITS			
*	D8210	Removable appliance therapy	SC	NC
*	D8220	Fixed appliance therapy	SC	NC

* **REQUIRES PTAR**

January 1, 2004			Under 21	21 & Over
		OTHER ORTHODONTIC SERVICES		
*	D8660	Pre-orthodontic treatment visit	17.00	NC
*	D8670	Periodic orthodontic treatment visit (as part of contract)	0	0
*	D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s)	SC	SC
	D8690	Orthodontic treatment (alternative billing to a contract fee	SC	NC
	D8691	Repair of orthodontic appliance	SC	NC
	D8692	Replacement of lost or broken retainer (limited to one only)	SC	SC
	D8999	Unspecified orthodontic procedure, by report	SC	SC
XII.		D9000 - D9999 ADJUNCTIVE GENERAL SERVICES		
		UNCLASSIFIED TREATMENT		
	D9110	Palliative (emergency) treatment of dental pain - minor procedure	46.85	37.20
		ANESTHESIA		
	D9210	Local anesthesia not in conjunction with operative or surgical procedure	12.80	10.15
	D9211	Regional block anesthesia	11.65	9.65
	D9212	Trigeminal division block anesthesia	10.15	8.00
	D9215	Local anesthesia	12.80	10.15
	D9220	Deep sedation/general anesthesia - first 30 minutes	79.75	79.75
	D9221	Deep sedation/general anesthesia - each additional 15 minutes	67.00	53.15
	D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	18.60	14.95
	D9241	Intravenous conscious sedation/analgesia - first 30 minutes	110.60	88.25
	D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes	40.10	50.30
	D9248	Non-intravenous conscious sedation	NC	NC
		PROFESSIONAL CONSULTATION		
	D9310	Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment (Telephone consult not covered. If the consulting provider provides the treatment, it will be considered a referral, no consultation fee will be allowed.)	39.90	31.90

* **REQUIRES PTAR**

January 1, 2004		Under 21	21 & Over
	PROFESSIONAL VISITS		
D9410	House/extended care facility call	15.95	15.95
D9420	Hospital call	114.85	91.95
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	NC	NC
D9440	Office visit - after regularly scheduled hours, requires description	29.75	26.60
D9450	Case presentation, detailed and extensive treatment planning	NC	NC
	DRUGS		
D9610	Therapeutic drug injection, by report	35.05	27.60
D9630	Other drugs and/or medicaments, by report	21.30	17.05
	MISCELLANEOUS SERVICES		
D9910	Application of desensitizing medicament	20.25	16.45
D9911	Application of desensitizing resin for cervical and/or root surface, per tooth	NC	NC
D9920	Behavior management, by report (D.D. patients only, if necessary)	100.00	100.00
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report	45.20	36.20
D9940	Occlusal guard, by report	SC	SC
D9941	Fabrication of athletic mouthguard	NC	NC
D9950	Occlusion analysis - mounted case	15.95	15.95
D9951	Occlusal adjustment - limited	SC	SC
D9952	Occlusal adjustment - complete	SC	SC
D9970	Enamel microabrasion	NC	NC
D9971	Odontoplasty 1 - 2 teeth; includes removal of enamel projections	NC	NC
D9972	External bleaching - per arch	NC	NC
D9973	External bleaching - per tooth	NC	NC
D9974	Internal bleaching - per tooth	NC	NC
D9999	Unspecified adjunctive procedure, by report	SC	SC

EXPLANATION OF SYMBOLS

* Requires Prior Authorization
\+ Not Authorized for Recipients over 18 years of age
❑ Frequency Limits
SC "Special Consideration: will be given the claims preceded by an "SC". The provider of service must submit a PTAR with a full explanation of the procedure justifying the service and amount claimed. The explanation should accompany the claim when billed.
NC "Not a Covered" Service

A GUIDE FOR ORTHODONTIC SCREENING

FOR NORTH DAKOTA HEALTH TRACKS NURSES

PREFACE

This guide was written to assist nurses in understanding orthodontic terminology and to establish basic guidelines for screening and referral of children. The information presented in the guide covers only the malocclusions used in the North Dakota Health Tracks (formerly EPSDT) interceptive and comprehensive orthodontic indexes. The guide includes basic suggestions for orthodontic screening procedures.

INTRODUCTION

"Orthodontic treatment includes the diagnosis, prevention, and treatment of dental and facial irregularities. These irregularities often take the form of malocclusions--problems with the way the teeth fit together."

In most cases, malocclusion is hereditary, caused by differences in the size of the teeth and jaw, and cannot be prevented. Sometimes, however, malocclusion is the result of habits such as finger- or thumbsucking, tongue thrusting, mouth breathing, or by losing baby teeth too soon.

More than half of the children age 12-17 suffer from malocclusions that can be corrected by orthodontic treatment. In some cases mild malocclusions primarily affect appearance. More severe cases of malocclusion can interfere with chewing ability, can create tension and pain in jaw joints, and can result in facial deformities leading to emotional problems. Crowded or crooked teeth are more difficult to clean, and this can lead to increased tooth decay or periodontal disease. Health Tracks (formerly EPSDT) screening for orthodontic problems is important so referral for treatment can be accomplished.

There is a lack of uniformly acceptable standards defining the degree of deviation from ideal occlusion severe enough to be considered an orthodontic problem. The Dental Health Program developed this guide to assist in training Health Tracks (formerly EPSDT) screeners, as well as to standardize oral screening procedures performed statewide. The criteria outlined in this guide are not intended to be used before the screener receives professional instructions consisting of classroom lecture(s) with an accompanying slide presentation and hands-on experience on models or clients.

TRAINING OBJECTIVES

To be able to:

- Understand basic orthodontic terminology
- Understand basic treatment options under the Health Tracks Program
- Recognize normal occlusion
- Estimate the degree of abnormality measured in millimeters
- Given an abnormal condition, estimate if the client meets the eligibility criteria set forth in the orthodontic indexes
- Recognize attitudes and behaviors that may contraindicate orthodontic treatment

ORTHODONTIC TREATMENT OPTIONS UNDER HEALTH TRACKS

Orthodontic treatment under the Medicaid Program includes two treatment options:

1) Interceptive Orthodontic Treatment and
2) Comprehensive Orthodontic Treatment

Interceptive Orthodontic Treatment

Interceptive orthodontic treatment is the early treatment of developing malocclusions. The purpose of interceptive orthodontic treatment is to lessen the severity of the developing malocclusion. Interceptive treatment does not preclude the need for further treatment at a later age.

"The presence of complicating factors such as skeletal disharmonies, overall space deficiency, or other conditions requiring present or future comprehensive therapy are beyond the realm of interceptive therapy. . . . Early phases of comprehensive therapy may utilize some procedures that might also be used interceptively in an otherwise normally developing dentition, but such procedures are not considered interceptive in those applications."

Interceptive treatment under the Medicaid program will include only treatment of anterior and posterior crossbites and minor treatment for tooth guidance in the transitional dentition. This could include treatment for an ectopic incisor (a severely malpositioned incisor). Points are not used in the interceptive screening process.

Comprehensive Orthodontic Treatment

Comprehensive orthodontic treatment is the coordinated diagnosis and treatment of malocclusions leading to improvement in the patient's craniofacial dysfunction and/or dentofacial abnormality. Treatment usually includes fixed orthodontic appliances (braces), but may also include procedures such as extractions and maxillofacial surgery. Treatment may incorporate several phases with specific objectives at various stages of dentofacial development. The child must be Medicaid eligible at the beginning of the treatment phase.

Comprehensive orthodontic treatment under the Medicaid program includes treatment of handicapping malocclusions in the transitional or adolescent dentition. Eligibility for treatment is determined by use of an orthodontic index. Children must have 20 or more points on the index to be eligible for treatment. Special consideration may be given if the points are between 18 and 20 and x-rays and a narrative description are submitted to the Medicaid Dental Consultant for review.

ORTHODONTIC SCREENING

An orthodontic screening is not a diagnostic examination and does not take the place of a complete orthodontic evaluation. An orthodontic screening identifies children with occlusion abnormalities. It is a visual inspection aided by the use of a tongue blade and an orthodontic ruler or gauge.

Based on the eligibility criteria set forth by the Health Tracks Program (formerly EPSDT) and outlined in this guide, children will be referred to an enrolled dental provider for a complete evaluation.

When to Start Screening Children for Orthodontic Referral

INTERCEPTIVE

Children 7-10 years of age should be screened for eligibility for interceptive orthodontic referral.

COMPREHENSIVE

A good age to begin screening children for comprehensive orthodontic referral is about 10-11 years of age. By this age a majority of the permanent teeth have erupted. Since the criteria in the current orthodontic index will allow only the most severe cases for treatment, it is most efficient to begin screening when this determination can most easily be made.

This procedure will save time for both the screener and the enrolled provider. The screener will not be wasting time completing the orthodontic screening on children too young to make a complete determination because the permanent teeth have not erupted. The enrolled provider will not be wasting time completing orthodontic evaluations on children who may never even come close to meeting the criteria for eligibility, even though they may have some degree of malocclusion. There will also be a cost savings to the program since funds will not be expended to complete orthodontic evaluations on children who will not be eligible for treatment.

Children being treated in phases do not need to be rescreened at the beginning of Phase II if they have been prior approved for Phase I. However, the child must be Medicaid eligible at the beginning of Phase II or arrangements must be made with the family as with any other private pay patients.

When to Refer for Orthodontic Evaluation

INTERCEPTIVE

Children who have anterior or posterior crossbites and/or ectopic incisors should be referred for further orthodontic evaluation for interceptive treatment. Points are not used in the interceptive screening process. If any of the three conditions covered under the interceptive treatment program are present, a referral to a participating provider can be made by checking the appropriate condition(s) identified on the referral form.

COMPREHENSIVE

The orthodontic index sets 20 points as the minimum necessary to be eligible for orthodontic treatment. Since there will be some variability in the measurements and some malocclusions which non-dental professionals may miss, screeners should refer all cases which have 18 or more points. Some unusual cases may not meet the 20 point minimum for eligibility, but still may represent some very serious problems. In any cases requiring special consideration for unique circumstances, the screener should consult with the enrolled provider in the area and the State Health Tracks Administrator.

CLEFT LIP/CLEFT PALATE

Children with cleft lip cleft palate can be referred immediately. No points are necessary for this referral.

POSITIONING OF TEETH FOR CLASSIFYING MALOCCLUSIONS

The child should position his/her teeth in centric position - the most unstrained and functional position of the jaws, in other words, the way the child normally bits his/her teeth together. Some children have difficulty doing this when asked and may have a tendency to bite the front teeth edge-to-edge. To assist the child in positioning the teeth in centric position, have the child place the tip of their tongue back on the roof of the mouth and bite together.

USE OF SCREENING RESULTS

Referrals:

- Based on eligibility criteria established by the Health Tracks (formerly EPSDT) Program, referrals should be made to dental providers participating in the program.

- Screening results should be shared with parents even if the child does not meet the eligibility criteria for a referral. Some families may be able to afford orthodontic care in the future if their situation changes.

HEALTH TRACKS INTERCEPTIVE ORTHODONTIC SCREENING FORM

Name_____ Date_____

This referral for evaluation for interceptive orthodontic treatment is based on: (check all that apply)

1. Anterior crossbite _____
2. Posterior crossbite _____
3. Ectopic incisors _____

Comments:_____

_____

_____

_____

Any child with one or more of the conditions listed above can be referred to an enrolled dental provider for evaluation. Points are not used in the interceptive screening process.

Screener_____

HEALTH TRACKS COMPREHENSIVE ORTHODONTIC SCREENING FORM

Name_____ Date_____

Have the child position their teeth in centric position.
Record all measurements in the order given and round off to the nearest millimeter (mm).

Score all conditions listed.

1.	Overjet in mm		_____
2.	Overbite in mm		_____
3.	Mandibular protrusion in mm	x 5	_____
4.	Anterior open bite in mm	x 4	_____
5.	# of impacted anterior teeth (upper and lower arch)	x 5	_____
6a.	Moderate crowding - allow 2 points per arch		_____
6b.	Severe crowding - allow 4 points per arch		_____
7a.	# of teeth in anterior crossbite	x 2	_____
7b.	# of teeth in posterior crossbite	x 2	_____
8.	Habits affecting arch development - allow 2 points (finger or thumbsucking, tongue thrusting)		_____
		TOTAL	_____

Any child with 18 or more points should be referred to an enrolled dental provider for evaluation. For any cases requiring special consideration, consult with the enrolled provider and the State Health Tracks Administrator.

Screener_____

UNDERSTANDING MALOCCLUSIONS

Classification of malocclusions is a complex undertaking. In defining a screening procedure, we will define normal occlusion and note deviations from this as possible orthodontic problems. Some of the most common malocclusions used in the Health Tracks orthodontic indexes are illustrated and described in further detail on the following pages.

Normal: All the teeth in the maxillary (upper) arch are in maximum contact with the mandibular (lower) arch, with the upper teeth slightly overlapping the lower teeth. The mesiobuccal cusp of the maxillary permanent first molar occludes in the buccal groove of the mandibular first molar. (Figure 1)

Figure 1 Normal Occlusion

MALOCCLUSIONS CONSIDERED IN INTERCEPTIVE SCREENING

Referral for evaluation for interceptive treatment is based on the three conditions listed below. No measuring is necessary for interceptive referral.

1. **Anterior crossbite** - Any of the upper front teeth are lingual (behind) the lower front teeth. (Figure 2)

Figure 2 Anterior Crossbite

2. **Posterior crossbite** - The upper or lower posterior teeth are either buccal (outside) or linqual (inside) to their normal position. (Figure 3)

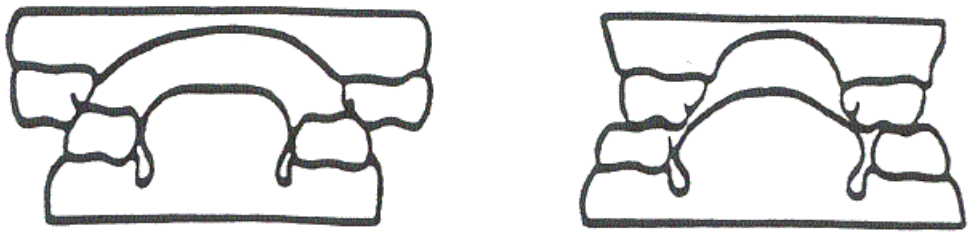


Figure 3 Posterior Crossbite

3. **Ectopic Incisor** - An ectopic incisor is a severely malpositioned incisor.

MALOCCLUSIONS CONSIDERED IN COMPREHENSIVE ORTHODONTIC SCREENING

1. **Overjet** - The upper front teeth are too far in front of the lower front teeth. Teeth may or may not look crooked. (Figure 4)

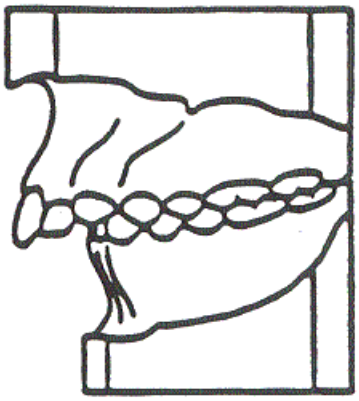


Figure 4 Overjet

How to measure: Record the largest overjet of the most protruding upper incisor (front tooth) with the metric ruler. Round off to the nearest millimeter. This is a horizontal measurement. (Figure 5)

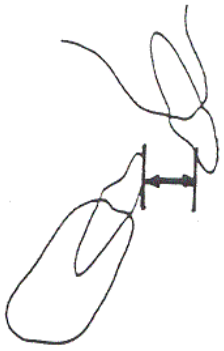


Figure 5 Measuring Overjet

2. **Overbite**: The upper front teeth come down too far over the lower front teeth, sometimes causing the lower front teeth to touch the gum tissue behind the upper front teeth (upper teeth could also hit lower gums). (Figure 6)

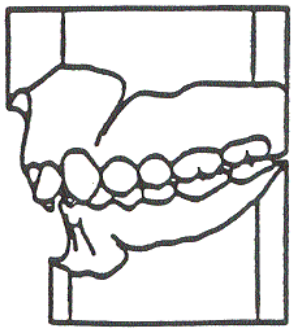


Figure 6 Overbite

How to measure: Using the metric ruler, measure the depth of the overbite by determining how far down the upper front teeth bite over or cover the lower from teeth. This is a vertical measurement. (Figure 7)

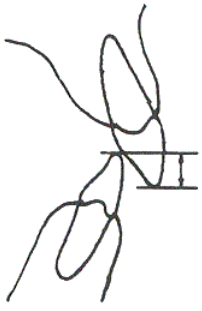


Figure 7 Measuring Overbite

3. **Mandibular Protrusion (mandibular overjet)**: The lower front teeth are too far in front of the upper front teeth. (Figure 8)

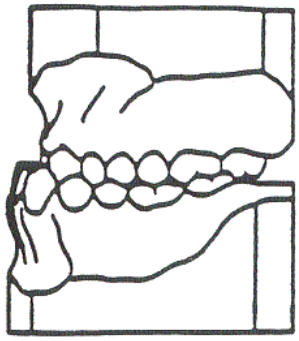


Figure 8 Mandibular Protrusion

How to measure: Record the largest overjet of the most protruding lower incisor (front tooth) with the metric ruler. (Figure 9)

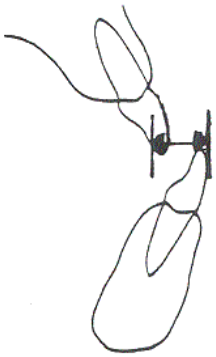
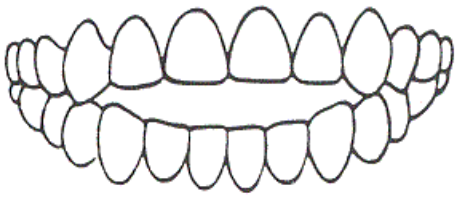


Figure 9 Measuring Mandibular Protrusion

4. **Anterior Openbite**: The anterior (front) teeth cannot be brought together and a space remains. (Figure 10)



Openbite. Lack of incisal (end) contact. Posterior teeth in normal occlusion.

Figure 10 Openbite

How to measure: Record the largest openbite with the metric ruler. (Figure 11)

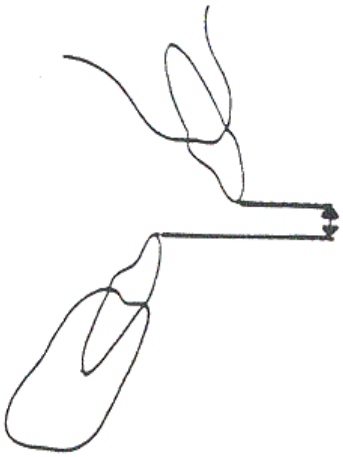


Figure 11 Measuring Openbite

5. **Impacted teeth (anterior only)**: Teeth which have developed but have not erupted in the mouth. (Figure 12)

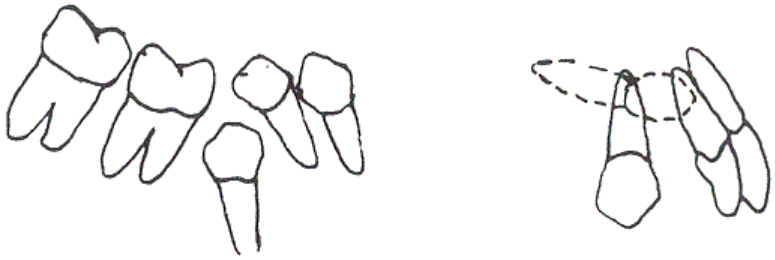


Figure 12 Impacted Teeth

How to measure: This is difficult to diagnose without an x-ray. A screener can best estimate there may be an impacted tooth if the child is beyond the age when the tooth normally erupts and there is still no sign of the tooth. Use the eruption chart as your guide. (See Appendix D)

6. **Crowding**: Space in the arch is insufficient to accommodate all the teeth in normal alignment.

    a. **Moderate crowding** - Less than one tooth blocked out. Some teeth may be slightly rotated or out of line due to lack of space. The lack of space is usually less than 6 mm.

b. **Severe crowding** - Insufficient space is usually more than 6 mm. One or more teeth are blocked out. A child with severe crowding will usually need extractions to create space. The lack of space can be represented by one tooth completely blocked out or by a number of teeth partially blocked out. (Figure 13)

Figure 13 Crowding

How to measure: Evaluate and record each arch (jaw) separately. If less than one tooth is completely blocked out or a number of teeth are partially blocked out but do not equal more than 6 mm of space, this is recorded as moderate crowding.
If one or more teeth are completely blocked out or a number of teeth are partially blocked out and the lack of space is more than 6 mm, this is recorded as severe crowding.

Be sure to score each arch.

7. **Crossbite**:

a. **Anterior crossbite** - Any of the upper front teeth are lingual (behind) the lower front teeth. (Figure 14)

Figure 14 Anterior Crossbite

b. **Posterior crossbite** - The upper or lower posterior teeth are either buccal (outside) or lingual (inside) to their normal position. (Figure 15)

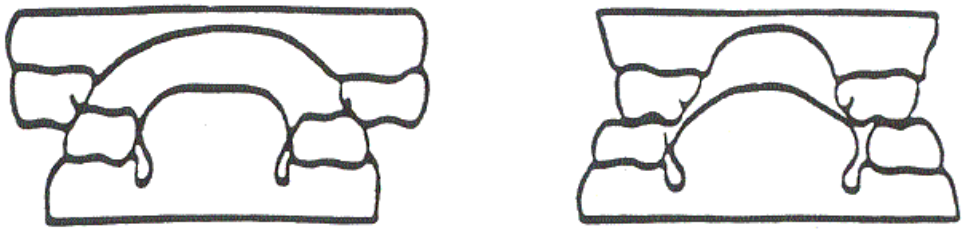


Figure 15 Posterior Crossbite

How to measure: Evaluate anterior and posterior regions of the mouth separately. Record the number of teeth in each region that are in crossbite.

8. **Habits which Affect Arch Development**:

finger or thumbsucking
tongue thrusting

How to measure: Sometimes a child may have a habit which causes a malocclusion or exacerbates an existing occlusion problem. You may need to question the parent to see if the child had a prolonged finger or thumbsucking habit which continued beyond age 5.

Tongue thrusting can be observed by watching the child swallow. The tongue will protrude between the teeth when the child swallows if he/she has a tongue thrusting habit.

It is often difficult to determine if a finger or thumbsucking or tongue thrusting habit affects the dental arch development without the use of special diagnostic tools. If a screener observes an obvious tongue thrust or can easily determine the child had a prolonged finger or thumbsucking habit, points should be recorded.

INFECTION CONTROL PROCEDURES FOR SCREENING

Hands should be washed before and after screening each child and a new pair of gloves should be worn for each child. A new metric ruler and tongue blade should be used for each child. If dental mirrors are used, disposable ones are recommended. If metal mouth mirrors are used, they must be sterilized after each use. Preferred methods of sterilization are autoclave, dry heat, or chemical vapor.

All disposable screening supplies should be placed in trash bags. Trash bags should be tied shut and properly disposed of according to state and locate waste disposal regulations.

CONCLUSION

In public programs the costs of screening potentially eligible clients can be minimized by having well-trained staff to obtain index scores. Children meeting the established criteria should be referred to an enrolled dental provider for further evaluation.

In addition to orthodontic index scores other factors to be taken into account in decisions on eligibility for orthodontic treatment include the satisfaction of individuals with their own dental appearance, their interest in improving their dental appearance, and their willingness to undergo treatment and comply with the instructions of the dental provider.

This manual is meant only to be a guide. Some cases or conditions may require special consideration even though they do not fall in the 18 and over point range for referral. In all these cases, the screener should consult with the local dental provider and the State Health Tracks Administrator.

APPENDIX A

GLOSSARY

Adolescent dentition	the teeth that are present after the normal loss of primary teeth and prior to cessation of growth
Anterior teeth	the six front teeth, incisors and cuspids (eyeteeth)
Buccal	the surface of the posterior teeth facing the cheek
Ectopic incisor	a severely malpositioned incisor (front tooth)
Impacted	a tooth which has developed but not erupted in the mouth
Incisal	the biting surface of the anterior teeth
Lingual	the surface of the tooth facing the tongue
Malocclusion	any deviation from the ideal normal relationship
Mandibular arch	the lower dental arch
Maxillary arch	the upper dental arch
Occlusion	the contact of the teeth in the lower arch with those in the upper arch
Posterior teeth	the premolars (bicuspids) and molars
Transitional dentition	the final phase of the transition from primary to adult teeth in which primary teeth are shedding and permanent teeth are emerging

APPENDIX B

HEALTH TRACKS COMPREHENSIVE ORTHODONTIC INDEX

Name_____ Date_____

Occlude patient or models in centric position.
Record all measurements in the order given and round off to the nearest mm.

Start by measuring overjet of the most protruding incisor. Measure overbite from La-incisal edge of overlapped incisor to point of maximum coverage.

Score all conditions listed.

1.	Overjet in mm		_____
2.	Overbite in mm		_____
3.	Mandibular protrusion in mm (Class III cases only)	x 5	_____
4.	Anterior open bite in mm	x 4	_____
5.	# of impacted anterior teeth (upper and lower arch)	x 5	_____
6a.	Moderate crowding - allow 2 points per arch		_____
6b.	Severe crowding - allow 4 points per arch		_____
7a.	# of teeth in anterior crossbite	x 2	_____
7b.	# of teeth in posterior crossbite	x 2	_____
8.	Habit which affects arch development - allow 2 points		_____
		TOTAL	_____

NOTE: Unless special consideration is given, 20 points is the minimum ordinarily considered for eligibility. The Orthodontic Consultant will determine medical necessity on a case by case basis.

APPENDIX C

SCREENING SUPPLIES

- Tongue blades or dental mirrors
- Disposable gloves
- Flexible metric rulers*
- Flashlight or penlight (optional)
- Screening forms
- Pencils
- Trash bags

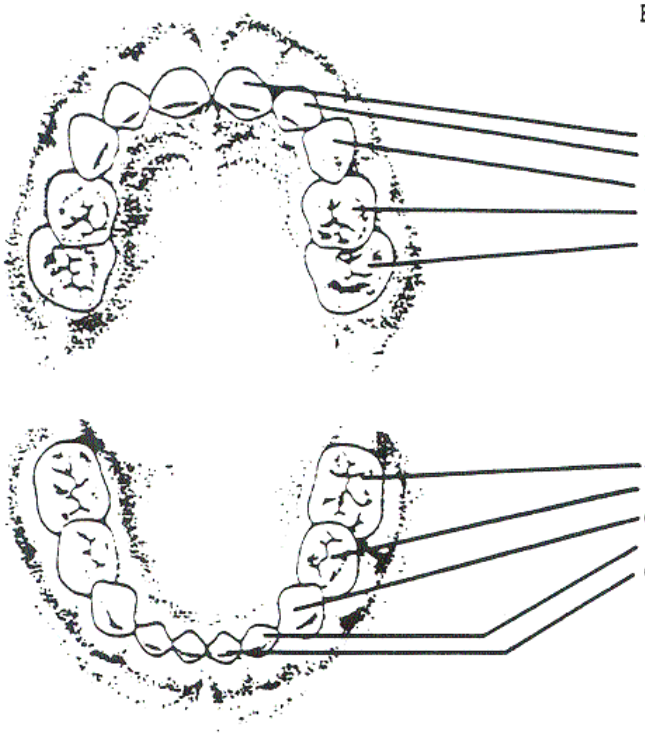
*Flexible metric rulers in millimeters can be ordered from:

Ormco
1332 S Lone Hill Ave
Glendora, CA 91740-5339
Telephone: 1-800-435-4837

Patterson Dental Company
524 N 7th St, PO Box 2246
Fargo, ND 58108
Telephone: 701-235-7387

APPENDIX D

TOOTH ERUPTION CHART

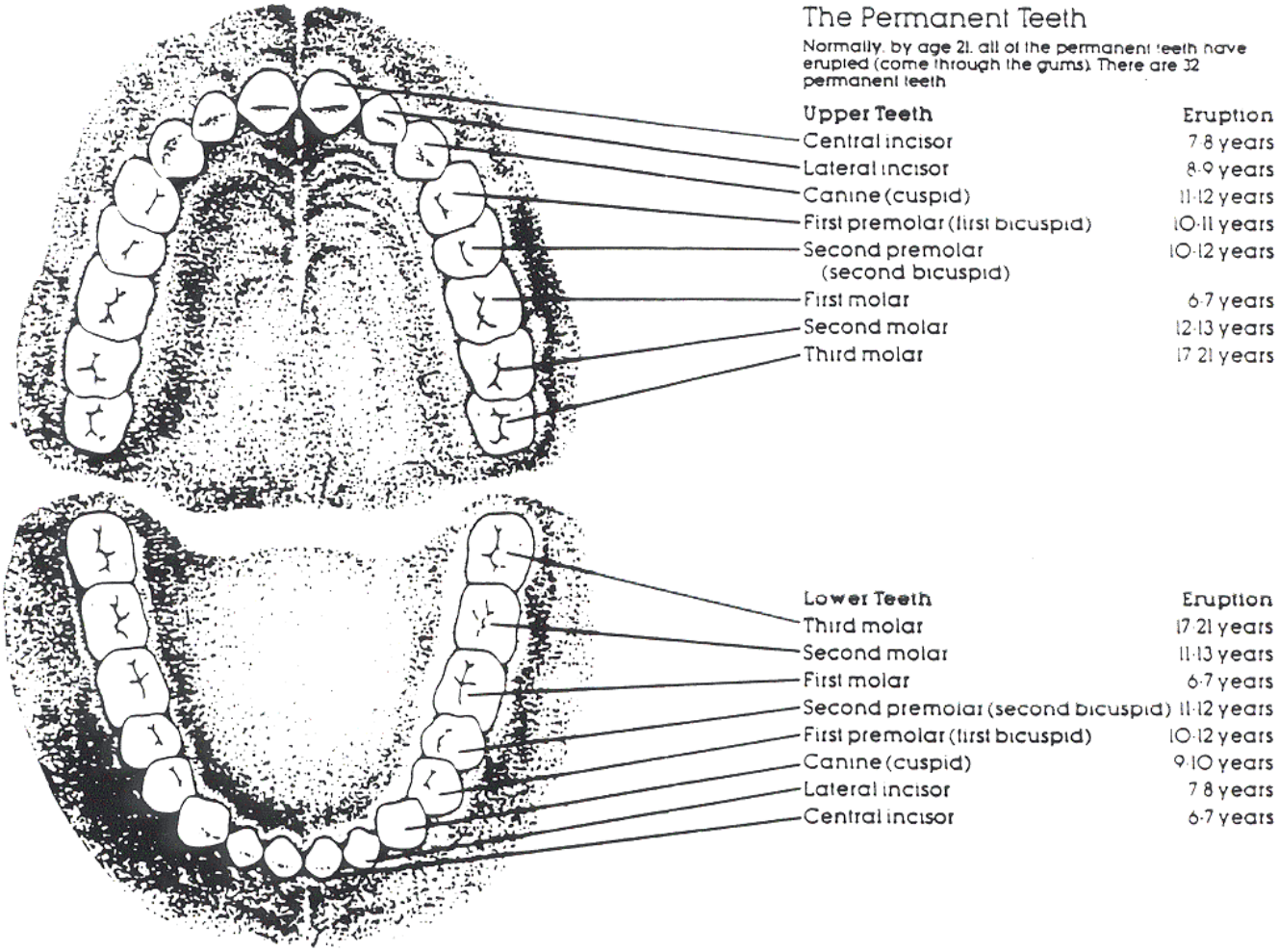


ERUPTION AND SHEDDING OF PRIMARY TEETH

UPPER TEETH	ERUPTION DATE	SHEDDING DATE
central incisor	8-12 months	6-7 years
lateral incisor	9-13 months	7-8 years
canine (cuspid)	16-22 months	10-12 years
first molar	13-19 months	9-11 years
second molar	25-33 months	10-12 years

LOWER TEETH		
second molar	23-31 months	10-12 years
first molar	14-18 months	9-11 years
canine (cuspid)	17-23 months	9-12 years
lateral incisor	10-16 months	7-8 years
central incisor	6-10 months	6-7 years

APPENDIX E


The Permanent Teeth
Normally, by age 21, all of the permanent teeth have erupted (come through the gums). There are 32 permanent teeth.
Upper Teeth
Eruption
Central incisor
7-8 years
Lateral incisor
8-9 years
Canine (cuspid)
11-12 years
First premolar (first bicuspid)
10-11 years
Second premolar (second bicuspid)
10-12 years
First molar
6-7 years
Second molar
12-13 years
Third molar
17-21 years
Lower Teeth
Eruption
Third molar
17-21 years
Second molar
11-13 years
First molar
6-7 years
Second premolar (second bicuspid)
11-12 years
First premolar (first bicuspid)
10-12 years
Canine (cuspid)
9-10 years
Lateral incisor
7-8 years
Central incisor
6-7 years

APPENDIX F

EASY REFERENCE GUIDE FOR HEALTH TRACKS ORTHODONTIC SCREENING AND REFERRAL

INTERCEPTIVE ORTHO

- Children age 7-10 screened
- No point system used
- Conditions referred
  - Anterior crossbite
  - Posterior crossbite
  - Ectopic incisor

COMPREHENSIVE ORTHO

- Children age 10-11 screened
- Children with 20 or more points eligible for treatment
- Conditions considered in point system
  - Overjet
  - Overbite
  - Mandibular protrusion
  - Anterior open bite
  - Impacted teeth
  - Crowding
  - Anterior crossbite
  - Posterior crossbite
  - Tongue thrusting or thumbsucking
- Other factors to consider
  - Child's oral hygiene
  - Child and parent's willingness to comply with treatment

CLEFT LIP AND CLEFT PALATE

- Cases are an immediate referral
- No points used for evaluation